

**Health Information and Quality Authority  
Social Services Inspectorate**

**Inspection report  
Designated centres for older people**



<b>Centre name:</b>	TLC Centre, Maynooth
<b>Centre ID:</b>	0684
<b>Centre address:</b>	Straffan Road
	Maynooth, Co Kildare
<b>Telephone number:</b>	01-6549600
<b>Fax number:</b>	01-6549200
<b>Email address:</b>	Tania@tlccentre.ie
<b>Type of centre:</b>	<input checked="" type="checkbox"/> Private <input type="checkbox"/> Voluntary <input type="checkbox"/> Public
<b>Registered providers:</b>	TLC Limited
<b>Person in charge:</b>	Tania Spelman
<b>Date of inspection:</b>	13 October 2009 and 14 October 2009
<b>Time inspection took place:</b>	<b>Day-one start:</b> 08:00hrs <b>Completion:</b> 18:00hrs <b>Day-two start:</b> 07:50hrs <b>Completion:</b> 17:45hrs
<b>Lead inspector:</b>	Valerie McLoughlin
<b>Support inspector:</b>	Linda Moore
<b>Type of inspection:</b>	<input type="checkbox"/> Announced <input checked="" type="checkbox"/> Unannounced
<b>Purpose of this inspection visit</b>	<input type="checkbox"/> Application to vary registration conditions <input type="checkbox"/> Notification of a significant incident or event <input type="checkbox"/> Notification of a change in circumstance <input checked="" type="checkbox"/> Information received in relation to a complaint or concern

## 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 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 on specific matters arising from a previous inspection to ensure that the action required of the provider has been taken
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Social Services Inspectorate (SSI) 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 wellbeing 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 purpose-built single story centre with 84 places. The centre is surrounded by six acres of landscaped gardens with an orchard, a bowling green and an enclosed courtyard.

Accommodation for residents consists of 26 twin en suite bedrooms and 38 single en suite bedrooms. Eight single and two twin en suite bedrooms are designated as a unit to care for residents with Alzheimer's or dementia.

The centre has five sitting rooms, three recreation rooms and one overnight guest room for relatives. Other facilities include a kitchen, laundry service, two dining rooms and a coffee dock. There is a hairdressing salon, a library, a cinema, an oratory, a meeting room and staff changing facilities.

There are automatic gates at the main entrance and closed circuit television (CCTV) in public areas. There are ample parking facilities.

### Location

The centre is situated in the countryside of Kildare, just off the N4, two km from Maynooth town.

<b>Date centre was first established:</b>	31 October 2008
<b>Number of residents on the date of inspection</b>	68

<b>Dependency level of current residents</b>	<b>Max</b>	<b>High</b>	<b>Medium</b>	<b>Low</b>
<b>Number of residents</b>	27	5	14	22

### Management structure

The Person in Charge reports directly to the Chief Executive Officer of TLC, Dr Liam Lacey, who is one of the Providers. Staff nurses report to the Person in Charge, Tania Spelman, the senior care staff report to the staff nurse on duty, and the care staff report to the senior care staff. Catering staff are managed by the catering supervisor, who in turn reports to the Person in Charge. The Person in Charge is supported by activities staff, administrative, laundry, housekeeping, maintenance and portering staff.

<b>Staff designation</b>	<b>Person in Charge</b>	<b>Nurses</b>	<b>Care staff</b>	<b>Catering staff</b>	<b>Cleaning and laundry staff</b>	<b>Admin staff</b>	<b>Other staff</b>
<b>Number of staff on duty on day of inspection</b>	1	3	11	4	3	1	3

## Background

This was an unannounced inspection carried out in response to information received from two separate people. Both were concerned about the large number of admissions to the centre in a short space of time. They were also worried that there were not enough staff on duty to care for residents. These issues were fully reviewed during the inspection and the inspectors focused on staffing resources and the quality of care, including nursing care. The person in charge was informed of the purpose of this inspection at the initial meeting on the day.

A contract had been agreed on 31 August 2009 by the provider with an acute hospital for the admission of residents to the provider's services. There was an agreed schedule for these admissions and 50 residents were to be admitted over a three-month period. However, this was not adhered to and residents were admitted from the hospital to this centre at a rate of two to three residents per working day over a one-month period.

## Summary of findings from this inspection

The inspectors spoke with 17 residents and five relatives and listened to their views. The inspectors also read two questionnaires completed by relatives during the inspection. The inspectors spoke with the person in charge and staff, observed practice and reviewed documentation and policies.

The inspectors did not find clear evidence that the provider had employed sufficient staff members to ensure that the admission process was adequately carried out for the significant number of residents who moved to the centre in a short space of time. The staff rota did not confirm that sufficient numbers of staff were in place delivering care in a consistent manner during this period.

Inspectors found serious weaknesses in the systems of delivery of safe, quality care. On the day of the inspection, staff members were not organised to do this in an effective manner. There were serious deficits in staff training. The nursing care in the centre was not well organised or supervised and did not make the best use of the clinical resources. The practices in the administration of medication and care planning were not safe. Residents were not fully assessed when admitted to the centre and a robust care plan was not developed with them.

During the inspection, inspectors brought one instance of unsafe care to the attention of the person in charge and provider who took immediate action. After the inspection, three care plans were required to address the needs of some of the residents.

The inspectors concluded that the providers and the person in charge did not show good judgment in admitting residents at this pace and the serious care issues are detailed throughout this report.

The inspection team met with the providers on 4 November 2009 to discuss the issues arising from this inspection and in particular the rapid increase of residents to the centre over a short period of time for which the centre was not adequately prepared. The Authority will be following up on all matters raised in this report. A further unannounced inspection of this centre has since taken place and the report of that inspection will be published by the Authority in due course.

## Issues covered on inspection

### 1. Staffing

#### *Staff resource and the admission of residents*

Prior to expanding, the centre's occupancy was at approximately 30 residents. A contract had been agreed on 31 August 2009 by the provider with an acute hospital for the admission of residents to the centre. Admissions under this contract commenced on 1 September 2009, and 40 residents were admitted in the 30 days prior to the inspection. On the day of inspection, the person in charge could not tell the inspectors how many extra staff had been recruited to care for the 40 additional residents. There were two new staff nurses who had just completed orientation and one new nurse starting orientation. The person in charge told the inspectors that the centre received assistance from another TLC Centre in admitting residents. There was no record of these additional staff on the rota. Inspectors asked the five staff nurses on duty, over the course of the inspection, about the staff who came to assist the admissions process during the previous month. The staff said that no additional help came from another centre, except for one person who came to "give us some pointers". The staff told the inspector that they had received 30 residents to the centre in one month, admitting two to three residents per day and on one day five residents were admitted. The inspectors reviewed the register and noted that 40 residents were admitted to the centre over a one-month period. Some staff nurses said there was not enough qualified staff on duty and that the use of agency staff did not help to maintain continuity of care.

The person in charge was unable to tell the inspectors what system of care delivery was in place. During the inspection it was apparent that a "task allocation" system was being used and this did not facilitate person-centred care, appropriate allocation or skill mix of staff to meet residents' needs. There was no structured system for the organisation of care delivery, such as a key worker system or a "named nurse" concept or some similar system to promote continuity of care for residents.

There was no system in place to determine the number or skill mix of staff required to care for the residents. Residents' actual dependency levels did not match the dependency levels recorded in their files and some of the dependencies reviewed by the inspectors were not reflective of the residents' current dependency status. An evidenced-based tool was not used to determine the staff ratio and skill mix required to deliver high quality safe effective care to the residents. The actual rota in place was not reflective of the staff on duty in that agency staff, and staff replacing those on sick leave, were not reflected on the rota. It was not possible to determine the actual number of staff on duty during the period of time when 40 residents were admitted to the centre from the rota in place. The inspectors asked for clarification on how staffing

levels and skill mix was determined to provide care for these residents. The information provided did not explain how staffing levels were determined.

### ***System of communicating residents' care needs.***

The inspectors joined the handover between the night and the day staff at 8am. While there were two staff nurses on night duty, only one nurse provided the handover. The care plans were not used during the meeting and as a result the handover did not contain sufficient detail about the residents' needs to enable staff to provide consistent, adequate care. The two new staff nurses said that the handover did not provide enough information to look after the residents. They said, "The care staff would tell you what the residents care needs are."

The senior care staff and care staff had a separate handover together, which was not informed by information from the nurses' meeting. A staff nurse did not oversee this handover, or provide any direction following this handover. As a result, the care staff did not receive adequate guidance on how to prioritise residents' care. On asking one senior care staff member how she organised and supervised the carers, she said, "We start at one end (of the unit) and work our way up (to the end of the unit)." Senior care staff and care staff were not adequately supervised or supported.

### ***Orientation and support for new staff***

On the day of the inspection there were no records in place to indicate the orientation and training that new staff had received. The staff spoken with did not feel adequately informed or supported to care for residents. The inspectors observed an agency nurse who had worked in the centre for one week being allocated to administer medications with a newly recruited staff nurse. Neither staff member was familiar with all the residents. Staff nurses said that a clinical nurse manager who had recently resigned needed to be replaced to support them in their work. There was no structured system in place for the supervision of new staff.

### ***Staff training***

There were deficits in specialist training for staff to meet the complex needs of this group of residents.

Mandatory training was not completed by all staff, such as fire training and evacuation. Two newly employed registered nurses had not received fire training and when the fire alarm was activated during the inspection, the nurse was not clear about her role in the event of a fire. This posed a potential risk to residents' safety. These staff had not seen the fire policy. Of the 55 staff employed in the centre only 16 staff had received mandatory training on manual handling and this posed a risk to residents and staff. Six registered nurses had completed (cardiopulmonary resuscitation) CPR training.

There was no evidence of a formal mentorship programme in place, an individual performance development plan or appraisal system to assist staff in maintaining their competence and receiving feedback on their performance.

Some clinical training had been given to staff. Two staff nurses and seven carers had received training in the management of behaviour that challenges. One registered nurse held a diploma in gerontology. Eleven staff members had received training in dementia care.

### ***Residents' and relatives' views***

When asked how residents were cared for, some relatives said that residents "had a long time waiting to have the call bell answered". On asking how this affected the care of the residents, relatives said:

- "Had a long time waiting to go to the bathroom"
- "Put to bed early as not enough staff available in the evening"
- "Meals were cold"
- "Waiting in the dining room for over an hour for lunch"
- "Not being taken out to the garden".

One relative wrote in the questionnaire that: "Many of the staff are dedicated and excellent, but I am never updated about (resident's) condition unless I ask."

## **2. Healthcare needs**

### ***Peripatetic services***

The centre has two designated general practitioners (GPs) who review residents when required, and uses an out-of-hours GP service if necessary. There was access to psychiatric services as required. Residents had access to support services such as physiotherapy, occupational therapy, dietician, chiropody, speech and language therapy, audiology, ophthalmology and dental care when required.

### ***Medication management***

The systems and practices to manage and administer medication were not safe. The inspector spoke to the nurse who said, "If there was a medication error on day duty the night nurse would pick up on it when she came back on duty." The inspector reviewed medication administration charts and found that a higher dose of a medication had been administered to one resident on two separate occasions. This change in dosage had not been authorised by a doctor. The medication administered is known as a "high alert" medication, which means that extra care and attention is required during checking and administration due to the level of risk associated with it. This error had not been detected by the centre. The person in charge was requested to submit an investigation report on this incident to the inspection team.

On the second day of inspection, the inspector observed that the medication trolley was left unlocked on the residents' bedroom corridor. The medication blister packs were left on top of the trolley and were accessible to 30 dependent residents on the unit who had a history of confusion. This unsafe practice posed a risk to residents who could have taken this medication inadvertently.

The inspector read the medication management policy and noted that it was not in line with the An Bord Altranais Medication Administration Guidelines (2007). Medication was not being administered in line with the policy in place or best practice. For example, in administering crushed medications and in administering medications covertly. Crushed medications were being administered on the day of inspection without a doctor's prescription. Two new nurses had not read this policy and did not know where to find it.

The inspectors observed that medications administered were recorded by the staff nurse using initials. As there was no nurse signature list to refer to, it was not possible to know who had administered the medications. The nursing home used agency staff nurses and their names were not recorded on the duty rota. There was a risk that a staff member who had administered a medication would not be identifiable should it be necessary to investigate an incident or medication error.

The staff nurse told the inspector that two staff nurses usually administered the medications to all of the residents which "can take three to three-and-a-half hours to

complete and then it's time to start again". While these two nurses were administering medications, there was only one nurse available to provide supervision and support the care staff.

The nursing staff said that they usually counted the controlled drugs twice per shift but that they had been too busy the previous night to check the medication. However, there was no record maintained in the centre of the twice-daily checks required as per the policy. The person in charge addressed this issue immediately, when it was brought to her attention. On the day of the inspection, the medication count was correct.

### ***Care planning***

On the day of the inspection there was no admission or assessment policy in the nursing home to guide staff in these processes. The person in charge informed the inspector that these policies were in the process of being updated.

Residents did not have a formal pre-admission assessment completed prior to moving into the centre. No comprehensive nursing assessment was in place. Care plans were not person centred and did not consistently outline what specific care the residents required, the frequency of when care was required or what grade of staff was responsible for care provision. For example, one care plan stated: "monitor blood pressure regularly." The blood pressure was recorded only on one occasion on 26 September 2009. One relative said that staff needed more supervision and training as monitoring charts were not completed fully.

One resident with a history of dementia did not have an assessment of communication needs except a record which read "history of dementia". One assessment recorded that a resident was agitated but, there was no behavioural assessment in place and no record of measures to be used to alleviate the agitation. Rather, the assessment stated "needs supervision with activities of living". This was inadequate for care planning purposes.

While there was a comprehensive record of the residents' previous medical history, many of the residents' details were not recorded, such as marital status, former occupation, and residents' understanding of admission. Some residents said that no one had asked them if they wanted to live in this centre – one resident said "the hospital advised me to come here".

### ***Dementia care***

Although there were 52 residents in the centre with a history of dementia and / or Alzheimer's, the five staff nurses from day and night duty were not aware that there was a policy in place for caring for these residents. Only two staff nurses on duty had received training in caring for residents with dementia and 11 staff members in total received training in this area.

The Alzheimer's unit was staffed by two care staff who were very competent in their role and nursing cover was available to them. However, there was no registered nurse assigned to this area. This contributed to poor outcomes of care for one resident and inadequate care planning for another resident that inspectors reviewed.

### ***Management of behaviour that challenges***

Inspectors observed one resident receiving chemical restraint (medication that sedates). While there had been consultation with the family and doctor prior to the prescription of the medication for restraint purposes, there was no record that a risk assessment for this restraint had been undertaken in the centre. This method of restraint had been used in the hospital from which the resident was discharged. However, a new assessment had not been carried out, taking into account the very different residential environment.

There was no record of alternative measures being considered or tried prior to the use of chemical restraint. The complex decision making required to administer a medication for the purpose of chemical restraint was not sufficiently informed and supervised as no nurse was designated to work in this area.

### ***Pain management***

One resident told the inspector that she was in severe pain. This resident and her daughter were very distressed. The inspector looked at the resident's nursing notes, her medication record and talked to the staff nurse. This resident had an ulcer (where an area of the skin has broken down) and was receiving prescribed pain medication twice a day as prescribed and twice a week prior to dressing change. The resident's pain level was not being assessed. There was no care plan in place to indicate how this resident's pain should be managed.

### ***Wound care***

The inspector met a resident who required wound care dressings of chronic wounds. This resident's history indicated that wound healing was already compromised and would require careful attention. Inspectors noted that there was an offensive odour from the dressing. While the staff had consulted a tissue viability nurse (wound specialist) to obtain advice on this resident's wound management, there were no records in place of the outcome of this consultation. The wound assessment completed by the nursing staff was not comprehensive and was not reflective of the requirements of an evidenced-based assessment. The care plan did not indicate what date the dressings were due for renewal or review. When the inspector asked the staff nurse when the dressings were due to be changed the staff nurse told the inspector that the dressings were due to be changed the previous day but were not redressed as "they were too busy". Subsequent to inspection, a detailed care plan was received by inspectors on this issue.

### ***Bowel monitoring charts***

Bowel monitoring records were not completed fully and in some instances there were no records maintained for seven days.

### ***Blood glucose monitoring***

Where residents required blood glucose monitoring, there was no evidence in the care plan or on the charts as to how frequently monitoring was required. This posed a risk that variable practices of care could develop which could place a resident's health at risk.

### ***Falls prevention and management***

The accident and incident records over a three-and-a-half month period were reviewed by inspectors. Accident and incidents were reported and recorded, but not audited. As a result there was no structured approach to the prevention and management of falls which was the predominant nature of the incidents recorded. Some residents with a history of falls did not have a falls risk assessment completed on admission. One resident did not have a reassessment following a fall, despite having had an adverse outcome from it. While the person in charge was in the process of forming an interdisciplinary falls prevention and management team, this had not been implemented. On the day of inspection, there was no structured programme for quality improvement in falls prevention and management. Staff training in this area was inadequate, as the training records provided state that only one staff nurse and one care staff received training.

### ***Nutritional needs***

Many residents said that they enjoyed their meals and received assistance when required. However, nutritional needs were not consistently assessed on admission, even where it was recorded on transfer notes that there was a history of a poor appetite. The assessment, care planning of nutritional needs and monitoring intake and output were not recorded fully or consistently.

For example, a resident's care plan stated "assess" nutritional need, and monitor the weight "periodically". There was no indication of what assessment was to be undertaken. The resident's weight was recorded on admission only.

A care plan stated, "Provide food as per likes and dislikes". There was no record of what foods this resident liked or disliked. Where nutritional risk assessments were used, the information obtained was not used consistently to plan and direct residents' care. The carers were not very clear on why residents' intake was being monitored or how to complete a fluid balance chart. Only five care staff received training on healthcare needs.

### **3. Quality of service provision**

#### ***Interactions with staff***

The inspectors observed that the staff on duty on both days of the inspection had a positive regard for the residents and were interested and motivated in caring for older people. Staff had a good rapport with residents and with each other. Residents told the inspectors the staff were "very friendly, kind and caring". One resident said, "The staff are my family". Other residents said that they had made friends in the centre, and some residents said "I love it here" or "I am very happy here".

There was evidence that the staff had a caring attitude towards the residents and were dedicated to their work. They worked diligently to meet the needs of the residents and communicated with them in a respectful and courteous manner. Staff members felt that their suggestions had been listened to and their ideas had been implemented. For example, one staff member had suggested that the care staff take a designated allocation of residents to care for over one month so that they can "get to know the residents' likes and dislikes".

#### ***Promoting independence***

There was evidence that residents' independence was promoted. There was a full-time physiotherapist in the centre who carried out individualised assessments and was actively seen walking with residents and providing exercises for dependent residents. Many residents said were very happy as their independence had improved since they came to the centre and they felt that this was the result of having regular physiotherapy and walks with the activity staff.

One resident had a motorised scooter which she said she enjoyed driving around the centre, and she said, "This gives me great independence." Specialist chairs and mobility aids were available to residents.

#### ***Dining experience and nutritional needs***

The dining room was well staffed and supervised by a catering manager who was very attentive to residents' needs. The dining experience was a social event for most residents. There was soft background music, which created a relaxed environment. The tables were set with tablecloths, napkins, condiments and fresh flowers.

There was a choice of two main courses on the menu and residents said that they were always provided with a choice of meal. The inspector joined the residents for lunch with their permission, and noted that the choice of two main courses was reflective of the three-week rotating menu. The inspector had lunch and found that the food was plentiful, hot, attractively presented and very tasty. There was a variety of fruit juices and hot drinks available. Specialist diets were presented in an attractive and appetising

manner. Some family members assisted their relatives with their meals and staff provided assistance as required to dependent residents. Staff interacted well with residents and provided assistance to residents in a dignified and unrushed manner. On the day of inspection one lady celebrated her 91<sup>st</sup> birthday during lunch and a special birthday cake was provided.

### ***Activities***

The inspectors noted that the centre employed three activity staff who provided a wide range of activities which included story telling, newspaper group, bingo, baking and music and physical exercise. The activities programme was available to residents, including some "one-to-one" activities, provided by the activities coordinators. Residents told the inspectors how they enjoyed taking part in many of the activities, for example, they told the inspectors how that they enjoyed watching sport and movies in the cinema room. One resident said that he goes out to the pub where there is, "a sing-along". Many of the residents loved getting their hair done on Thursday and Fridays in the hairdressing salon. They said it was lovely to have their hair nicely groomed for the weekend.

While relatives were very complimentary about the activities staff and the range of activities provided, some said, "there is not enough staff to take the residents outside, and there is not enough staff to do one-to-one activities."

### ***Management of complaints***

Inspectors read one record of a written complaint that had been addressed. The centre did not maintain records of verbal complaints received. The person in charge told the inspectors that all verbal complaints were managed promptly and that residents and family can approach her at any time. As there was no record maintained of verbal complaints, there was no way to identify whether issues were fully resolved, recurrent or managed to the residents' or relatives' satisfaction. As a result there a valuable opportunity lost for learning how to improve the service and residents' satisfaction.

Family members and residents spoken with confirmed that they knew who to talk to if they had any concerns. There were conflicting reports from relatives about their level of satisfaction in how complaints were managed in that some were satisfied with the outcomes and some were not.

The complaints policy did not include a methodology for investigating a complaint, and therefore the management of complaints was not readily transparent. An independent person had not been identified to manage an appeals process should it be required.

## ***Policies***

The majority of policies were not reflected in the practices in the centre. They were not authorised by the person in charge and did not have an implementation or review date. The person in charge had commenced a review of many of the policies. However, there was no evidence that staff were aware of the policies in place such as the medication administration policy, the care of residents with dementia policy and wound care assessment. There was no evidence that staff had received training in any amended policies or that the updated policies had been implemented.

## ***Report compiled by***

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

25 November 2009

## Provider's response to inspection report

<b>Centre:</b>	TLC Centre, Maynooth
<b>Centre ID:</b>	0684
<b>Date of inspection:</b>	13 October 2009 and 14 October 2009
<b>Date of response:</b>	30 December 2009

### 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 and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

#### 1. The provider has failed to comply with a regulatory requirement in the following respect:

- the staffing levels and skill mix were not appropriate to the needs of the residents and the size and layout of the building and residents' healthcare needs were not consistently met, for example, in pain management and wound dressings not being carried out as required
- there was no actual staff rota available, and there was no evidence of the allocation of staff
- staff were not supervised on an appropriate basis pertinent to their role.

#### Action required:

Put in appropriate numbers and skilled staff based on the assessed needs of the residents at all times.



<ul style="list-style-type: none"> <li>there was no evidence of assessing behaviour before chemical restraint was used which would be in line with the centre's restraint policy.</li> </ul>	
<b>Action required:</b> Submit a restraint assessment and care plan for this person's restraint management.	
<b>Reference:</b> Health Act 2007 Regulation 6: General Welfare and Protection Regulation 8: Assessment and Care Plan Standard 10: Assessment Standard 11: The Resident's Care Plan	
<b>Please state the actions you have taken or are planning to take with time scales</b>	<b>Time scale</b>
Provider's response:  Following your inspection and request for full restraint assessment and care plan for this resident, this information was submitted to HIQA on the 16th of October.	Actioned

<b>3. The provider has failed to comply with a regulatory requirement in the following respect:</b>	
<ul style="list-style-type: none"> <li>recently employed staff on duty on both days of inspection were not aware of the procedures in the event of fire.</li> </ul>	
<b>Action required:</b> Make adequate arrangements for all people working at the designated centre to receive suitable training in fire prevention.	
<b>Action required:</b> Carry out fire drills and practices at suitable intervals, for persons working at the designated centre and, insofar as is reasonably practicable, residents, are aware of the procedures to be followed in the case of fire.	
<b>Reference:</b> Health Act 2007 Regulation 32: Fire Precautions and Records Standard 26: Health and Safety	

Please state the actions you have taken or are planning to take with time scales	Time scale
<p>Provider's response:</p> <p>Arrangements have been made that all staff receive training in fire prevention. Fire drills are carried out weekly. During these fire drill staff are trained to converse with residents and families to inform them of the fire drill procedure.</p> <p>Fire drills are an integral part of our mandatory induction course which is now being held at regular intervals to facilitate all new staff.</p>	<p>Part of our mandatory induction. Ongoing</p>

<p><b>4. The provider has failed to comply with a regulatory requirement in the following respect:</b></p> <ul style="list-style-type: none"> <li>▪ scheduled controlled drugs set out by the Misuse of Drugs Regulations, 1988 and 1993, were not recorded as required by legislative requirements.</li> </ul>	
<p><b>Action required:</b></p> <p>Record scheduled controlled drugs as required by legislative requirements.</p>	
<p><b>Reference:</b></p> <p>Health Act 2007 Regulation 33: Ordering, Prescribing, Storage and Administration of Medicines Standard 14: Medication Management</p>	
Please state the actions you have taken or are planning to take with time scales	Time scale
<p>Provider's response:</p> <p>A record schedule of controlled drugs is in place as per legislative requirements.</p>	<p>Actioned</p>

<p><b>5. The provider is failing to comply with a regulatory requirement in the following respect:</b></p> <ul style="list-style-type: none"> <li>▪ medications were left unattended on top of an unlocked medication trolley on a corridor accessible to vulnerable residents</li> <li>▪ the medication administration policy was not specific to the centre, and was not in line with current professional guidelines</li> <li>▪ new staff were not aware of the centre's medication policy.</li> </ul>	
<p><b>Action required:</b></p> <p>Develop appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents.</p>	
<p><b>Action required:</b></p> <p>Implement and train staff in the use of such policies and procedures.</p>	
<p><b>Reference:</b></p> <p>Health Act 2007  Regulation 33: Ordering, Prescribing, Storage and Administration of Medicines  Standard 14: Medication Management</p>	
<p><b>Please state the actions you have taken or are planning to take with timescales:</b></p>	<p><b>Timescale:</b></p>
<p>Provider's response:</p> <p>The medication policy has been reviewed and given to all staff nurses who in turn have received education sessions to ensure they are aware of correct policy and procedure in TLC Maynooth.</p> <p>All new staff nurses receive training in medication management on their induction course.</p> <p>The medication policy has been reviewed by the Director of Nursing.</p>	<p>Actioned</p>

<p><b>6. The provider is failing to comply with a regulatory requirement in the following respect:</b></p> <ul style="list-style-type: none"> <li>▪ some staff did not have mandatory training, including manual handling, infection control and basic life support</li> </ul>
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- some staff did not have education in relation to care of residents with dementia, wound management, falls prevention and management, pain management, infection control and the prevention detection and management of abuse
- some staff did not have sufficient education in recording and monitoring of fluid intake and output charts, food intake charts, bowel charts, blood glucose charts, and vital signs monitoring charts
- staff education on assessment, clinical risk assessment, care planning and evaluation to ensure residents have a comprehensive plan of care in place reflective of their assessed needs.

**Action required:**

The person in charge shall ensure that staff members have access to education and training to enable them to provide care in accordance with contemporary evidenced practice.

**Reference:**

- Health Act 2007
- Regulation 17: Training and Staff Development
- Standard 24 :Training and supervision
- Standard 26: Health and Safety
- Standard 30:Quality Assurance and Continuous Improvement

<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
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Provider's response:

A training needs questionnaire has been given to all staff members.

Qualified Manual Handling trainer in place employed by TLC. Manual handling courses being conducted on a weekly basis until all staff have completed their mandatory manual handling training.

All staff are being inducted. As of the 9<sup>th</sup> of December, 47 out of 55 staff members have completed their induction and healthcare training. Induction manual supplied to HIQA.

Induction training includes all documentation for carers, prevention of abuse, infection control etc..

The falls team have provided falls prevention training to all staff.

To be audited and a complete related training plan put in place by 28 February 2010.

<p>A qualified basic life support trainer has been employed by TLC. Basic Life support courses will commence 15<sup>th</sup> of February 2010. This training will include all staff nurses and senior carers and any other staff member that wishes to avail of it.</p>	<p>Actioned 15 February 2010.</p>
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<p><b>7. The provider has failed to comply with a regulatory requirement in the following respect:</b></p> <ul style="list-style-type: none"> <li>▪ residents recently admitted from hospital did not have a pre-assessment of health, personal and social care needs prior to admission</li> <li>▪ assessment and care planning was not person centred; residents and family were not involved in planning care. Residents did not consistently have comprehensive assessments on admission, risk assessments or care plans to direct appropriate evidenced-based care for residents. Re-assessment following a change in health status was not undertaken</li> <li>▪ care was not consistently provided or evaluated in line with best practice.</li> </ul>
<p><b>Action required:</b></p> <p>Assess each residents needs prior to them moving into the residential care setting, a full assessment on admission, and subsequently as required to reflect changes in need and circumstances during his / her period in residence.</p>
<p><b>Action required:</b></p> <p>The registered provider to ensure suitable and sufficient care to maintain the resident's welfare and wellbeing, having regard to the nature and extent of the resident's dependency and needs as set out in the care plan.</p>
<p><b>Action required:</b></p> <p>The person in charge shall keep the resident's care plan under formal review as required by the resident's changing needs or circumstances and no less frequently than at three-monthly intervals.</p>
<p><b>Action required:</b></p> <p>Devise individualised evidenced-based care plans which are developed and agreed with each resident or where applicable with their significant other and make the care plan available to each resident. Revise the residents' care plan, after consultation with them, unless it is impracticable to carry out such a consultation and notify the resident of any review.</p>

**Action required:**

Maintain appropriate records of all nursing care provided to the resident including, but not limited to, records for monitoring fluid intake and output, food intake, bowel records, wound care and blood glucose charts when these are required by residents.

**Reference:**

Health Act 2007  
 Regulation 6: General Welfare and Protection  
 Regulation 8: Assessment and Care Plan  
 Regulation 9: Health Care  
 Standard 10: Assessment  
 Standard 11: The Resident's Care Plan  
 Standard 13: Healthcare  
 Standard 30: Quality Assurance and Continuous Improvement

<b>Please state the actions you have taken or are planning to take following the inspection with timescales:</b>	<b>Timescale:</b>
<p>Provider's response:</p>	Actioned
<p>All nursing documentation has been comprehensively reviewed and updated, this continues to be reviewed.</p>	Actioned
<p>All admissions will be assessed in the hospital with a family member present if possible and as much personalised information taken prior to admission in keeping with our admissions policy and procedures.</p>	Current audit in progress to be finished by Friday 22 <sup>nd</sup> of January 2010.
<p>We have commenced Audits on all care plans of all residents who currently reside in TLC Maynooth. As part of our policy and procedure on care plans, each resident care plan will be reviewed on a three-monthly basis. A change in condition or circumstance of a resident may necessitate more regular review of an individual's care plan.</p>	To be complete with outcome 28 <sup>th</sup> February 2010.
<p>It will be the key worker's responsibility to ensure that the details of the individual care plan is followed.</p>	
<p>During the three-monthly care plan review, key family members will be contacted by a key worker in order for them to participate in the care plan if they wish.</p>	
<p>A staff-training-needs questionnaire has been issued to staff. A mandatory induction course has been put in place which includes all healthcare documentation.</p>	





<p>We intend in 2010 to carry out a survey for residents and family members in order that we might determine levels of satisfaction with the service provided by TLC Maynooth. This will allow us to encompass any suggestions which they might bring forward into our developmental plan for 2010.</p>	<p>Final outcome and report with outcomes 31 March 2010.</p>
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<p><b>10. The provider is failing to comply with a regulatory requirement in the following respect:</b></p> <ul style="list-style-type: none"> <li>▪ policies and procedures did not reflect or support practice in the centre</li> <li>▪ staff were not aware of the policies in place such as the medication administration policy, care of residents with dementia policy and wound care assessment.</li> </ul>	
<p><b>Action required:</b></p> <p>Provide training to staff which ensures they are familiar with, and implement all policies and procedures.</p>	
<p><b>Reference:</b></p> <p>Health Act 2007  Regulation 27: Operating Policies and Procedures  Standard 29: Management Systems</p>	
<p><b>Please state the actions you have taken or are planning to take with timescales:</b></p>	<p><b>Timescale:</b></p>
<p>Provider's response:</p> <p>The policies in TLC have been reviewed by the DON and disseminated out to the staff nurses in a structured manner. The CNM has been nominated to complete this task and get each staff nurse to sign off when he / she has completed this task.</p> <p>A staff-training-needs questionnaire has been given to all staff members. The result of this training needs analysis will be used in the formulation for our staff education programme for 2010. Our method of dealing with policies issue is by means of one to one education session, Clinical Nurse Manager to staff nurse. On completion of session the staff nurse is requested to sign that they are aware and understand the policies and procedures.</p>	<p>Actioned</p>

**Any comments the provider may wish to make:**

**Provider's response:**

On the day of the inspection, the inspectors documented that there were three nurses on duty. There was in fact a CNM on duty both days as well as the three staff nurses.

TLC had employed both agency staff nurses and carers that were not reflected on roster and as a result not recognised by the Inspectors.

It is important to point out that all the meals served in the dining room are supervised by the chef and every meal that is served is served hot by the chef directly from the bain-marie.

All our new residents were seen formally by our Director of Nursing prior to admission. All families were invited to visit TLC Maynooth and were requested to accept a place on behalf of their relative prior to transfer.

With regards to the debriefing meeting, I would like to point out that the feedback we received from the inspectors did not reflect the contents of the final HIQA report contained in this website. At this meeting the inspector assured us that the care of our residents was obviously of a very high standard and that the shortcomings observed were in our documentation and paperwork. I feel that this did not come across with sufficient clarity in this report.

**Provider's name:** Dr Liam Lacey, CEO

**Date:** 30 December 2009