

Health Information and Quality Authority  
Social Services Inspectorate

Inspection report  
Designated centres for older people



<b>Centre name:</b>	Tender Loving Care (TLC)
<b>Centre ID:</b>	184
<b>Centre address:</b>	Northwood Park
	Santry
	Dublin 9
<b>Telephone number:</b>	01-8628080
<b>Fax number:</b>	01-8628090
<b>Email address:</b>	<a href="mailto:info@tlccentre.ie">info@tlccentre.ie</a>
<b>Type of centre:</b>	<input checked="" type="checkbox"/> <b>Private</b> <input type="checkbox"/> <b>Voluntary</b> <input type="checkbox"/> <b>Public</b>
<b>Registered providers:</b>	TLC Centre Ltd.
<b>Person in charge:</b>	Tanya Grandon
<b>Date of inspection:</b>	7 September 2011
<b>Time inspection took place:</b>	<b>Start:</b> 11:30 hrs <b>Completion:</b> 17:15 hrs
<b>Lead inspector:</b>	Leone Ewings
<b>Support inspector:</b>	None
<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 type="checkbox"/> Information received in relation to a complaint or concern <input checked="" type="checkbox"/> Follow-up inspection

## About the inspection

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

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

Additional inspections take place under the following circumstances:

- to follow up matters arising from a previous inspection to ensure that actions required of the provider have been taken
- following a notification to the Health Information and Quality Authority's Social Services Inspectorate of a change in circumstance for example, that a provider has appointed a new person in charge
- arising from a number of events including information received in relation to a concern/complaint or notification to the SSI of a significant event affecting the safety or 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 Santry is a three story over basement purpose-built centre which provides care for up to 128 residents. Accommodation is provided over four floors. Thirty beds on the first floor are contracted by the Health Services Executive (HSE) for residents admitted by the Consultant Psychiatrist for Old Age.

The ground floor can accommodate 20 residents and has 16 single en suite rooms and 2 twin rooms with en suite shower facilities. The first floor can accommodate 46 residents in 10 single en suite rooms, and 18 twin en suite rooms. The second floor accommodates 40 residents with 16 single en suite rooms and 12 twin rooms with en suite. The third floor provides accommodation for 22 residents, in 14 single rooms, and four twin rooms.

There are two sitting rooms on the ground floor and seating is available at the large reception open area. The hairdressing salon, activities room and the oratory are located near the reception area. A new physiotherapy gym/exercise room has been opened recently for the residents use.

The main dining room/restaurant is on the ground floor, and is open all day with tea/coffee making facilities available for residents and visitors'. A smaller private dining area is available to residents for fine dining and family occasions.

There is a small private enclosed secure garden/patio to the rear of the premises. An external smoking room is available for residents located in the garden, with a television and call bell system. A wooden decking area and patio with additional tables and seating is available in the garden.

Each of the three upper floors has a dining room and a separate sitting room. The ground, first and second floors have a nurses' station and a bathroom with a hydrotherapy bath. The third floor has a smaller nurses' area. The floors are connected by two lifts and four stairwells.

There is car parking available to the front and side of the centre for relatives and other visitors. Staff car parking is on the basement level. Service areas such as laundry and kitchen and staff facilities are also on the basement level.

### Location

TLC Santry is located in Northwood Park, close to Santry village and Dublin Airport. It is accessible from the city centre and Swords by a number of bus routes.

<b>Date centre was first established:</b>	2004
<b>Number of residents on the date of inspection:</b>	120(+3 in hospital)
<b>Number of vacancies on the date of inspection:</b>	5

<b>Dependency level of current residents</b>	<b>Max</b>	<b>High</b>	<b>Medium</b>	<b>Low</b>
<b>Number of residents</b>	50	20	25	28

### **Management structure**

The Providers are Dr Liam Lacey and Michael Featherston. Both are closely involved with each of their three designated centres. Dr Liam Lacey is the nominated representative of the Provider. The Person in Charge is Tanya Grandon and she reports to Liz McKeon, Director of Clinical Services, who in turn reports to the Provider.

The Person in Charge is newly appointed and is supported in her role by two Assistant Directors of nursing, one who is newly appointed and five Clinical Nurse Managers 1 (CNM1) to whom the nursing staff and care assistants report to.

Household and catering staff report to a household and Catering Manager who reports to the Catering Services Manager who in turn reports to the Director of Clinical Services, along with maintenance and administration.

<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 ADON	7 +1 ADON	20	7	7	3	1*

\*Maintenance person

The person in charge was on annual leave but also attended the centre when the inspection was notified to her by staff.

## Background

The purpose of the inspection was to review the progress of the provider addressing the action plans following the last inspection on 15, 16 and 17 February 2011. Information received by the Authority was also reviewed by inspectors on inspection.

The inspection was also to follow up on notifications and reports, related to infection control and incident and accidents at the centre.

Further to the last inspection, an immediate action letter was issued to the provider which outlined improvements required to staff training related to fire safety and compliance with planned training, implementation of the smoking policy, completion of a schedule of works relating to fire compliance to the requirements of the statutory Fire Authority. A detailed response was received by the Authority on 20 February 2011, and was found to be adequate with regard to addressing immediate risks identified by inspectors.

In addition, seven action plans were issued to the provider required improvements to meet the requirements of the legislation:

- review of premises including third floor facilities and regularisation with planning legislation
- review of complaints management at the centre
- review of transcribing and prescribing policies
- vetting and guidance for volunteer workers
- review staffing arrangements in place out of hours and supervision of staff including staff turnover
- maintenance of the directory of residents.

## Summary of findings from this inspection

There were seven action plans from the previous inspection of 15, 16 and 17 February 2011. In addition five recommendations were also given to the provider. These actions were reviewed on inspection. Four of the actions were found to have been fully addressed; two had been partially addressed but were within the timeframe, one action relating to medication management had only been partially addressed.

The provider had submitted documentation following the last inspection of the key actions taken to address the non-compliances. Plans for building improvements on the third floor had been submitted and works commenced.

Overall, the response to the immediate action letter and inspection report was found to be satisfactory, and fully addressed the issues discussed with the provider and the person in charge.

## Issues covered on inspection

### **Fire safety procedures**

The fire safety management and staff training records were found to be up to date. Means of escape were clear and staff demonstrated to the inspector that they were familiar with emergency procedures. The smoking policy was being fully implemented. The inspector reviewed correspondence with residents and relatives outlining the need to implement this policy and the rationale for same.

### **Infection prevention and control measures**

The provider notified the Authority of a suspected outbreak of norovirus on 4 January 2011. Infection prevention and control measures were reviewed on inspection. The management of the suspected outbreak was found to be satisfactory and communication was maintained with the person in charge and the management team. Further to the registration inspection, improvements were planned to improve hand-washing facilities on the third floor. The staff working in the hygiene department and laundry were fully informed and followed policy and procedure, with regard to cleaning and laundry management.

However, the inspector noted the floor of the basement laundry, and cleaners' rooms did not have a washable surface in place. The maintenance manager told the inspector that this would be addressed on the maintenance schedule.

### **Complaints management**

Records of any complaints and/or issues received by the centre since the last inspection were reviewed by the inspector. Most issues were given verbally to staff, and responded to adequately. All complaints received had been documented and responded to by the complaints officer. The outcome of the complaint had been documented.

## **Actions reviewed on inspection:**

### **1. Action required from previous inspection:**

The registered provider shall submit written evidence that all the requirements of the statutory fire authority have been complied with.

This action had been addressed in full.

The provider has submitted a written report from their competent person relating to fire safety dated 1 June 2011, and received by the Authority on 3 June 2011.

### **2. Action required from previous inspection:**

The person in charge shall ensure that all volunteers have Garda Síochána vetting, and have their roles and responsibilities set out in a written agreement between the designated centre and the individual.

This action had been addressed in full.

A review of staff files took place by the inspector. A written agreement had been put in place by the person in charge. No volunteers were found to be working at present at the centre. Arrangements were in place that vetting procedures took place and the roles and responsibilities were outlined in the written agreement.

### **3. Action required from previous inspection:**

Review policies and ensure they are centre specific with regard to TLC Santry, and implemented by management of centre.

This action had been partially met and was still within the agreed timeframe of October 2011.

The person in charge told the inspector that a full review of policy and procedures had taken place. This had been lead by the director of clinical services. The review was still ongoing and within the timeframe agreed to complete on this action.

### **4. Action required from previous inspection:**

The person in charge shall ensure an up to date directory of residents is maintained in relation to every resident in the designated centre with the information as outlined by schedule 3 of the regulations.

This action had been addressed in full.

The inspector reviewed the directory of residents and found it had been accurately maintained and the information contained was up to date.

**5. Action required from previous inspection:**

Review practices associated with generation and checking of prescriptions sheets for signing by the general practitioner (GP) and ensure the policy is updated in line with An Bord Altranais guidelines (2007).

This action had been partially addressed.

Some improvements were observed in the overall medication management practices. The person in charge had reviewed the medication policy, particularly relating to transcription of medication and updated the policy to address practice issues identified in the last inspection. However, not all staff were found to be familiar with the requirements of the policy to ensure best practice was adhered to. While some nursing staff clearly followed the policy requirements, the inspector found that nursing staff did not consistently follow the policy guidance on transcription and administration of crushed medication. Frequent changes and generation of new medication management charts allowed for by the system were not consistently checked by another nurse. The detailed audit system implemented following the last inspection was not fully sensitive to this potential for medication error as it was not linked back to the medication management policies. The person in charge agreed to review this action immediately and put in place safeguards to ensure best practice. Further to the inspection she has updated the Authority on actions taken to ensure adherence to policy and best practice for medication management.

Improvements were found to be required to the management of percutaneous gastrostomy (PEG) tube and the administration of medication.

The person in charge contacted the Authority further to the inspection date on 15 September 2011. She notified that changes had been made to the medication kardex and she had met with the manager of the pharmacy in relation to printing of medication charts. The assistant director of nursing would undertake audit of crushing of medications, and they would review the training needs for nursing staff following the inspection.

**6. Action required from previous inspection:**

Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

This action had been addressed in full.

The staff rosters of actual and planned staffing had been accurately maintained. Staff were replaced using a relief panel of staff if required. Records of where staff worked in the centre were kept, and staffing was reviewed by the person in charge (or her deputy) on a daily basis.

## **7. Action required from previous inspection:**

Review and provide facilities available to each resident on the third floor, including hand washing, accessible shower and / or bathing facilities, and dining space. Provide thermostatic control valves or other suitable anti-scalding protection, at appropriate places in the premises.

This action had been partially met and was still within the agreed timeframes outlined below.

The provider said that the following schedule of works would take place:

"A monitoring system has been put in place to ensure that hot water is stored at 60 degrees Celsius and distributed at no warmer than 43 degrees Celsius. All thermostatically controlled valves have been tested and faulty thermostatically controlled valves have been replaced."

The inspector interviewed the maintenance manager and confirmed the plumbing works had taken place, and a regular programme of water temperature checks now took place day and night, in addition to a daily water tank check. There had been no difficulties or reports to maintenance of water being too hot. This aspect of the action plan had been addressed in full.

A plan is in place to have two wheel chair accessible showers converted and four hand washing sinks put in place over a four month period which will complete this aspect of the action plan by December 2011.

"We have had a meeting with our architect and builder in relation to the need to increase the dining accommodation. Our plan is to convert the dining room to a sitting room and the existing sitting room to a dining room. This sitting room together with the new planned quiet room/library, we believe will allow for sufficient floor space for that purpose. The proposed plan for the third floor includes:

- new nurses' station
- quiet room/library
- store room
- assisted bath

Will commence in January 2012 and will be completed with minimum disruption to residents, staff and visitors by 29 February 2012."

The inspector reviewed the completed wheelchair accessible shared shower room on the third floor and found the works to have been completed to a high standard.

The ramp to access the shower room had been removed and a level access shower/wet room was now in place. The provider had also submitted photographs of the works when they were completed.

The remaining works were planned for and efforts were in place to complete the works with minimal disruption to residents at the designated centre.

**Report compiled by:**

Leone Ewings  
 Inspector of Social Services  
 Social Services Inspectorate  
 Health Information and Quality Authority

11 October 2011

Chronology of previous HIQA inspections	
Date of previous inspection:	Type of inspection:
15, 16 and 17 February 2011	<input checked="" type="checkbox"/> Registration <input type="checkbox"/> Scheduled <input type="checkbox"/> Follow-up inspection  <input checked="" type="checkbox"/> Announced <input type="checkbox"/> Unannounced
25 August 2011	<input type="checkbox"/> Registration <input checked="" type="checkbox"/> Scheduled <input type="checkbox"/> Follow-up inspection  <input type="checkbox"/> Announced <input checked="" type="checkbox"/> Unannounced

### Provider's response to inspection report \*

<b>Centre:</b>	TLC Centre Santry
<b>Centre ID:</b>	184
<b>Date of inspection:</b>	7 September 2011
<b>Date of response:</b>	1 November 2011

### Requirements

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

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

Practices relating to transcribing and administration of crushed medication via percutaneous endoscopic gastrostomy tubes, were not found to be in line with the revised policy of the centre, and in line with Guidelines for Medication Management for Nurses and Midwives (2007).

Nursing staff were not found to be familiar with the policies associated with ordering, prescribing, storing and administering medication.

#### **Action required:**

Implementation of reviewed medication management policy in full in line with An Bord Altranais guidelines (2007).

Put in place a robust audit system to review scope of implementation of the policy.

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

<b>Reference:</b> Health Act 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management	
<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
Provider's response:  Our medication policy has been reviewed and updated.  Our audit system has been updated to better reflect the questions we need answering.  We have met twice with our pharmacy, who have updated our medication sheet to reflect two signatures when transcribing is necessary.  Our GPs are giving specific written instructions in relation to medications they prescribe for those residents who have a peg tube insitu, in particular where alternatives are unavailable. A list of medications unsuitable for crushing is being compiled for TLC by our pharmacy.	Complete

<b>2. The provider has failed to comply with a regulatory requirement in the following respect:</b>  Review of policies and procedures for TLC Santry incomplete.	
<b>Action required:</b> Review policies and ensure they are centre specific and fully implemented by the management of centre.	
<b>Reference:</b> Health Act 2007 Regulation 27: Operational Policies and Procedures Standard 29: Management Systems	
<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
Provider's response:  All policies have now been reviewed and are centre-specific. We are in the process of disseminating the policies in TLC Santry. Our policy review group is working on the implementation of the updated policies.	Review completed. Implementation will be completed by end of January 2012

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

Improvements were required to the third floor of the premises inclusive of hand-washing accessible shower and/or bathing facilities and dining space.

**Action required:**

Implement action plan submitted to the Authority on 1 July 2011 within the timeframes agreed.

**Reference:**

Health Act, 2007  
Regulation 19: Premises  
Standard 25: Physical Environment

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

**Timescale:**

Provider's response:

All rooms now have hand-washing facilities.

Accessible shower works have been completed  
The improvement to the dining area is on schedule

Dining area and other scheduled work will be completed by end January 2012.

Completed re  
sinks and  
showers.

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

**Provider's response:**

Having completed a follow up inspection from the February 2011 registration inspection, I am happy to report that we continue to work with the Health Information and Quality Authority in maintaining our service to our residents.

Once again, I need to acknowledge the input of all of our staff members in providing the standard of care which we continuously aspire to.

I want to take this opportunity to thank Mrs Tanya Grandon, Director of Nursing for her leadership of our team in TLC Santry.

We will continue to provide the highest possible standards of care to our residents going forward.

**Provider's name:** Dr Liam Lacey CEO TLC Group

**Date:** 28 October 2011