Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	TLC City West
Centre ID:	OSV-0000692
Centre address:	Cooldown Commons, Fortunestown Lane, Citywest, Co. Dublin.
Telephone number:	01 468 9300
Email address:	citywest@tlccentre.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	TLC Health Services Limited
Provider Nominee:	Noel Mulvihill
Lead inspector:	Nuala Rafferty
Support inspector(s):	Sheila McKevitt Gearoid Harrahill
Type of inspection	Announced
Number of residents on the date of inspection:	138
Number of vacancies on the date of inspection:	1

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

▪ to monitor compliance with regulations and standards
▪ to carry out thematic inspections in respect of specific outcomes
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
09 March 2016 09:30	09 March 2016 19:00
10 March 2016 05:00	10 March 2016 16:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 03: Information for residents	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 14: End of Life Care	Non Compliant - Moderate
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Substantially Compliant
Outcome 17: Residents' clothing and personal property and possessions	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This was an announced inspection and formed part of the assessment of the application for renewal of registration by the provider. The inspection took place over two days and as part of the inspection, practices were observed and relevant documentation reviewed such as care plans, medical records, accident logs, policies and procedures and staff files. The views of residents, relatives and staff members of

the centre were also sought.

As part of the application for renewal of registration, the provider was requested to submit relevant documentation to the Health Information and Quality Authority (HIQA). All documents submitted by the provider, for the purposes of application to register were found to be satisfactory. The nominated person on behalf of the provider and person in charge demonstrated knowledge of the Health Act 2007 (Care and Welfare of Residents in Designated Centre's for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland throughout the inspection process.

The fitness of the nominated person on behalf of the provider was determined by interview during the previous registration inspection process and through ongoing regulatory work such as inspections.
Recent changes to the clinical management team within the centre were found on this inspection with the person in charge and both assistant directors' of nursing commencing in post in recent months. Through the inspection process, all demonstrated satisfactory knowledge of their role and responsibilities and sufficient experience and knowledge as required by the legislation.

A number of residents' questionnaires were received by the Authority prior to and during the inspection. The opinions expressed through both the questionnaires and in conversations with the inspectors on site were broadly satisfactory with services and facilities provided. In particular, residents were very complimentary on the manner in which staff delivered care to them commenting on their good humour and respectful attitude.

Overall, evidence was found that residents' healthcare needs were met. Residents had access to medical officers and consultant geriatrician services within the centre. Access to allied health professionals such as physiotherapy, speech and language therapists and to community health services were also available.
However, improvements to the level of clinical governance and standards of care being delivered to residents were found to be required including effective supervision and work systems care planning and assessment.

The Action Plan at the end of this report identifies areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centre's for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland

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

Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

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

Findings:
A written statement of purpose was available that broadly described the service provided in the centre and contained all of the information required by Schedule 1 of the Regulations.

Judgment:
Compliant

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
There were sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose and a clearly defined management structure that identified the lines of authority and accountability.
The operational management team within the centre were supported by an overarching governance structure that included clinical, financial, maintenance and activities

managers who gave guidance, direction and coordination to the staff in the centre. Inspectors learned that there had been a very high turnover of staff during 2015 of up to 42%. Mostly healthcare and nursing staff.
This also included the full nursing management team. Through the inspection process, all demonstrated satisfactory knowledge of their role and responsibilities and sufficient experience and knowledge as required by the legislation. But it was also noted that none of the current team had a Gerontology qualification and there was little experience of and no specific qualification within the team, in auditing or analysis in order to drive improvements through learning.
The person in charge worked closely with the provider and clinical director. A nurse management system was in place and included the person in charge with two assistant directors of nursing and a team of four clinical nurse managers. Management meetings were well established and reviewed aspects of service provision such as; staffing, health and safety, training, complaints and other relevant issues some of which were seen to be actioned.

An annual review of safety and quality of care was also in place. A report on the review was available.
However although there was evidence that the systems in place were monitoring many aspects of the service provision, improvements were found to be required.
Findings relating to restraint practices, care planning and assessment, premises and risk management which are detailed under the relevant outcomes further in this report did not fully assure the inspection team that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

For example;
- Audit processes in place were not effectively monitoring practices and cultures found such as medication errors; personal care; privacy and dignity; assessing planning or recording of care.
- Medication management practices were not meeting professional standards required by the Nursing and Midwifery Regulatory Board in relation to administration or auditing practices. There was limited evidence of effective action or learning following medication errors and limited guidance available to nurses to ensure consistency of approcah in the administration of as required medicines.
- Documentation of care provision was not sufficiently accurate or complete to determine the standard of care delivered.
-Evaluations of care plans together with nursing progress notes and other supporting documentation to evidence the delivery of a high standard of care were not appropriately linked to give a clear and accurate picture of residents' overall health management.
-Appropriate skill mix to ensure the delivery of safe, suitable and sufficient care to residents' was not in place at all times. Despite evidence of ongoing recruitment, turnover and replacement of staff remained a challenge. It was also noted that on the night shift immediately preceding and during the inspection nursing staff levels were depleted by one on each day and could not be replaced. This is of concern given the potential risk to care delivery and governance given that staffing skill mix is at a minimum, baseline for professional nursing care. An action in relation to staffing is included under Outcome 18

Although a quality and safety review system was in place there was no appropriate formal audit process by the senior nurse management team to effectively monitor the standard of care delivered to residents. Audits on the care planning process were last conducted in 2014. Medication audits were conducted by the pharmacist but reviews of appropriate prescribing or administration practices with involvement of medical or nursing personnel were not conducted.

The report on the Annual Review of Care for 2015 contained lists of information available to evidence that systems were in place. But the report did not show the standard to which the centre was achieving compliance with the regulations through use of key performance indicators such as; reduction in use of restraint; reduction or prevention of falls; improvements in care planning and assessment. Other indicators to establish the standard of and safety and quality of service being delivered such as; occupancy; staff turnover, recruitment and retention; staff training; numbers of complaints/compliments received were not included.
The governance systems in place did not support consistent effective monitoring or transfer of learning to ensure improvements in the quality or safety of care delivered.

Judgment:
Non Compliant - Moderate

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

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

Findings:
Each resident had an agreed written contract which deals with the resident's care and welfare. The contract included all details of the services to be provided for that resident and the fees to be charged.
This included a list of facilities and services provided including laundry, meals, and housekeeping. Services offered in the centre which incurred additional fees were listed.

A guide to the centre available to all residents. This described the centre services, management, complaints procedure, and contact information for useful external bodies. A newsletter which included articles and photos of activities, outings, birthdays, holiday celebration and other events in the centre was regularly updated. Information on upcoming in-house events and also concerts, movie trips and events around St. Patrick's Day or the 1916 commemorations were detailed in the newsletter with pictures and simple language and on posters displayed in communal areas. Communal areas such as

the lobby also had information on display regarding the complaints procedure, evacuation instructions, detail's of staff on duty and contact details for advocacy services.

Judgment:
Compliant

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

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

Findings:
The centre was managed by a suitably qualified and experienced nurse. The person in charge held authority, accountability and responsibility for the provision of the service.

Through the Authority's fit person process it was noted that there was daily engagement in the governance, operational management and administration of the centre. The person in charge facilitated the inspection process by providing documents and having good knowledge of residents' care and conditions and also had the qualifications and experience required by the legislation.

Judgment:
Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:
Records set out in Part 6 of the Regulations were available and kept in a secure place. The Statement of Purpose and Residents' Guide was complete and available. A copy of the insurance cover in place was provided which meets the requirements of the Regulations.

The directory of residents was reviewed and was found to meet the requirements of the Regulations and was up to date with records of admissions discharges and transfers maintained.

Although not all records were reviewed on this visit, it was found that, overall, general records as required under Schedule 4 of the Regulations were maintained including key records such as appropriate staff rosters, accident and incidents, nursing and medical records and operational policies and procedures as required by Schedule 5 of the Regulations. Planned rosters were in place in all units and an actual working rota was maintained electronically. But although changes to the rota were made on the computerised rota in a timely manner it was noted that a final version was not printed and retained. Neither was an identified final version saved on the system at the end of the week, fortnight or month, which was 'locked' to prevent further editing so that the accuracy and security of the record could be assured and verified to meet data protection legislation and/or information governance requirements.

All records required under Schedule 3 of the Regulations were maintained in the centre. But improvements were required in respect of maintaining clinical records in accordance with professional standards and linking clinical assessments and risks with care plans to aid evaluation. Although for the majority of residents, healthcare needs were met, several key areas for improvement were required in the documentation of care provided.

Evidence that the delivery of suitable and sufficient care to meet residents' needs was not easily available or accessible. This included evidence of the provision of personal care to maintain good hygiene and skin integrity
Care delivery was recorded on an electronic touch screen system. It was found that these records were only available on the system for a number of days. Inspectors were told that these remained on the main system available to nurses for longer periods. But on review inspectors could not find evidence that all residents were provided with regular showers or baths. Records showed that residents did receive a body wash regularly and mostly on a daily basis but inspectors noted that there were some residents who had not received a shower or bath in over a month. Inspectors' asked if the person in charge could provide a printout of the frequency of showers provided to residents with maximum dependency need but learned this could not be easily provided. In a sample of those viewed, where care plans for pressure area care referenced the need for regular repositioning, up to date records were not maintained in all cases. Nurses' daily progress records did not provide enough detail on the overall status of residents. The notes did not always comment on the care delivered, signs of improvement or deterioration in physical emotional or psychological state. They did not indicate how the resident had spent their day. This meant that a general picture of each

person's overall health and well being could be not be determined.

The designated centre had completed written operational policies referenced in the previous report and as required by Schedule 5 of the Regulations. Policies including health and safety and risk management were available, and most policies, although not all, had been reviewed within a three year timeframe. Examples include the management of absconsion. The policy on the prevention, detection and response to abuse did not reflect current guidance issued by the Health Service Executive on Safeguarding Vulnerable Adults and the policy and procedures in place on use of restraint did not reference the most recent guidance from the Department of Health.

Other policies also required to be revised to ensure they gave sufficient guidance to staff, reflected current best practice and the regulations. These include; the medication management policy which did not specifically guide staff on the administration of as required medications and polypharmacy use. The creation, access to and destruction of records which did not guide staff on the safe retention of computer based records.

Judgment:
Non Compliant - Moderate

Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Governance, Leadership and Management

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

Findings:
Suitable arrangements were in place for periods of absence of the person in charge and the provider complied with his responsibilities to notify the Authority when a change occurred to both the person in charge and the nominated person to replace them. The fitness of the assistant director's of nursing to replace the person in charge in the event of her absence was determined through interview and during the inspection and had the qualifications and experience required by the legislation.

Judgment:
Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment

is promoted.

Theme:
Safe care and support

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

Findings:
A review of the use of restraint found that there was a reduction in the use of bed rails throughout the centre although bed rails were still in place for some residents. The use of bed rails and lap belts was reduced. A culture of promoting a restraint free environment with an increase in the use of alternative safety measures such as bed alarms, roll out mats and low -low beds was being established.
It was found that revised assessments were now in place for this type of restraint and were in the process of being completed. Evidence of alternatives considered or trialled was available although this was not always included or referenced in the assessments or in associated care plans. The assessment tools were not always fully or appropriately completed. Some of the types of alternatives recorded on the forms as trialled were not always relevant to the form of restraint in use. For example the alternative documented prior to using a lap belt for a resident in a wheelchair was listed as a low -low bed.

The inspectors reviewed the system in place to manage residents' money and found that reasonable measures were in place and implemented to ensure resident's finances were fully safeguarded. Also improvements related to the determination of resident's capacity to understand complex issues and make informed decisions were required.
The legal status of residents with dementia or cognitive impairments was not always established prior to or since admission. Assessment of capacity for all residents with a formal or suspected diagnosis of dementia or other cognitive impairment had not been conducted. An action in relation to this is included under Outcome 11.

The management of risks associated with negative peer interactions, absconsion and concerns in relation to unmet needs raised by relatives were reviewed during the inspection. A number of these were brought to the Authority's attention through the notification process by the person in charge throughout quarter 4 of 2015 and the first quarter of 2016. It was found that the person in charge had conducted and completed preliminary investigations into the more significant incidents. The reports of the investigations were reviewed during the inspection and discussed with the person in charge. In all cases the outcome of the preliminary investigations found there were no basis for conducting full investigations as no evidence to support the concerns was found. However, on review inspectors noted that there was little evidence contained within the reports to sustain the outcome. For example, where old bruising was noted to a resident's arms. Statements were taken from staff, family meetings were recorded and clinical documentation to support investigations into underlying infections was available but the detail in terms of where the bruising was located, reference to previous skin integrity checks to determine when it could have occurred, reference to possible other causes i.e. blood sampling or fall
were not included. Sufficient detailed evidence to support the outcome of a thorough

investigation process was not available.
Although it was noted that families appeared satisfied with the care of their relatives and with the outcomes of the investigations.
Some evidence that measures were in place to manage responsive behaviours was found. But positive behaviour support plans to ensure these measures were appropriately and consistently implemented were not developed. This is further referenced under Outcome 11 Healthcare and Outcome 9 Medication with relevant actions. Staff had received training on the prevention of elder abuse and all staff spoken too were clear on their role and responsibilities in relation to reporting abuse. Staff were also knowledgeable in recognising the possible signs and symptoms, responding to and managing abuse.
But it was noted that the centre policy on prevention of elder abuse was not updated to reflect the most recent HSE guidance on safeguarding vulnerable adults. An action in relation to this is located under Outcome 5.

Judgment:
Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

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

Findings:
Emergency lighting and fire fighting equipment, directional signage and appropriate fire procedures were available throughout the building.
The internal and external premises and grounds of the centre appeared safe and secure, with appropriate locks installed on all exterior doors and a register of visitors was available. A CCTV system was in place both internally on corridors and externally.
The centre was found to be visibly clean and clutter free.
Completed logs were maintained on daily, weekly, monthly and quarterly tests and checks of fire equipment, doors, exit routes and emergency lighting. Certification of testing and servicing of extinguishers, fire retardant materials and the alarm system were documented. The building's fire and smoke containment and detection measures were appropriate to the layout of the building and exits were free of obstruction. There was a policy around responding to emergency and evacuating the centre that identified the location of temporary accommodation for residents. All residents had personal emergency egress plans (PEEPs) which identified the cognitive understanding, level of mobility and evacuation notes of each resident. Although it was noted that all staff were not aware how to access this information to enable them assist each resident appropriately. All staff had received training in fire safety within the past 12 months and were familiar with what actions to take in the event of a fire. But the system in place to

ensure all staff knew the identity of the fire warden for each shift, from whom they would take instruction, was not sufficient. Inspectors found this person was identified verbally during handover which was not attended by all grades such as ancillary staff on duty.
Inspectors were told that simulated fire drills were held annually. Records of fire training listed the dates of drills and the staff present, though no details were recorded on the time of day, the time taken to complete, or the observations and learning taken from the drill. Weekly checks of the fire alarm were held to ensure it was in working order. Staff responded by calling the reception desk, where the fire panel was located, to confirm that it was a test. But regular practices of fire drills outside of training sessions were not held to ensure staff familiarity and competency.

Appropriate arrangements for investigating and learning from serious incidents/adverse events which identified residents who were at risk of falls and put in place appropriate measures to minimise and manage the risks was in place. This included review of residents identified as at risk by a physiotherapist who visited the centre regularly. Documentation viewed showed a reduction in the number and severity of falls since January 2016 had occurred.

Systems to support staff knowledge and implementation of best practice to ensure good infection prevention and control were in place.

Systems were also in place to manage risks associated with resident's leaving the centre without staff knowledge and medical emergencies. But improvements were required to ensure these systems were sufficient. A review of the system in place to manage risks of resident's absconsion was identified as required by the person in charge, after a resident had left the centre without staff knowledge some months ago. But this review had not taken place.
The system in place to manage medical emergencies, up to and including collapse was not clear with inconsistencies in staff knowledge and implementation. An emergency bag with appropriate equipment to deliver first aid was available at each nurses' station. This included wipes, pulse oxymeter, suction and oxygen tubing, ambu mask and a small cylinder of portable oxygen. An automatic external defibrillator (AED) was located behind the reception desk at the ground floor.
In the event of an emergency, inspectors were told that nursing staff would ring down to the assistant directors' office to ask for the AED to be brought up to the unit. On night duty they would contact the clinical nurse manager on duty.
Staff gave a variety of responses on how they would contact the manager in the event that they were not in the office. But none of the nurse managers carried a mobile phone, pager or other device to enable staff to contact them.
This was of particular concern on one unit where there was no full time nursing presence on the day shift throughout this inspection and where there was only one staff on duty on the night shift.
A policy and procedure to give staff guidance and ensure a timely and appropriate response to a medical emergency was not in place.

Judgment:
Non Compliant - Moderate

Outcome 09: Medication Management
Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:
Safe care and support

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

Findings:
Inspectors found that there were written operational policies in place in the centre relating to the ordering, prescribing, storage, and administration of medicines to residents.
Medicines were supplied to the centre by a retail pharmacy business in a monitored dosage system that consisted of blister packed medication. Medicines were stored securely in the centre in medication trolleys or within locked storage cupboards. A secure fridge was available to store all medicines and prescribed nutritional supplements that required refrigeration, and temperatures were checked and recorded on a daily basis. Controlled drugs were stored securely within a locked metal cabinet, and balances of all controlled drugs were recorded in the controlled drugs register. Nursing staff checked and documented the balances of all controlled drugs twice daily at the change of shift. Nursing staff were familiar with the procedure for disposing of unused or out of date medicines.

Inspectors observed nursing staff administering medicines to residents during the evening administration rounds on one of the units. The nurse knew the residents well, and was familiar with the residents' individual medication requirements. Inspectors observed that the nurses took time to ensure each resident was comfortable before administering their prescribed medicines in a person centred manner. Nurses were observed to use alcohol hand gels appropriately throughout the process. Medication administration practices were found to adhere to current professional guidelines.

Medication audits were conducted in the centre and inspectors reviewed a sample. It was noted that these audits were conducted by the external pharmacist and did not include nursing or medical inputs. These audits only covered some aspects of good medication management practices. The audits were conducted on a regular basis by the external pharmacist who supplied medicines to the centre. The audits looked at aspects such as; storage, labelling, administration records controlled medicine s and temperature controls on medicine refrigeration.

Medication errors were appropriately recorded and discussed at the drug and therapeutics committee. But in discussions with an assistant director of nursing the inspectors learned that action plans associated with follow up on these medication errors that included appropriate feedback to staff, identified and implemented any learning needs was not in place.
It was found that where errors that resulted in residents not being administered

medication at the prescribed time, these errors were not reported to the GP, although it was also found that the medication was subsequently administered up to some hours outside of the prescribed time frame which could negatively impact on the efficacy of the medicine and its' effect on the resident. Some of these errors related to administration of controlled drugs used for relief of intractable pain.

Issues related to prescribing practices were also noted. For those residents who were prescribed a number of medications on an as required basis to manage behaviours associated with dementia. Clear instructions were not available for nursing staff on the sequential administration of each medicine. This was of concern particularly where inspectors found that these medications were frequently administered. It was found that there was inconsistency of approach in relation to the use of these medicines. Examples relate to use of oral and subcutaneous medicines for anxiety related behaviours. Although some of the oral medications were prescribed for use up to a maximum of three times within a 24 hour period, on occasions it was found that nurses administered the subcutaneous form of medicine first. A clear rationale for the decisions to do this could not be ascertained from all of the records reviewed.

Also it was noted that there were many residents who inspectors were told were well, in that they did not have any acute health issues or were not clinically deteriorating were being prescribed high numbers of pro re nata (PRN) or as required medicines. Some residents were prescribed as many as 20 -22 of these medicines. Some had not been administered for long periods of time but had not been discontinued.

Judgment:
Non Compliant - Moderate

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

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

Findings:
A record of all incidents occurring in the designated centre was maintained and, where required, notified to the Chief Inspector.

Judgment:
Compliant

Outcome 11: Health and Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of

evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

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

Findings:
Residents had good access to GP and consultant geriatrician services. Regular reviews of residents overall health was found on admission, readmission following return from acute hospital care and as required when clinical deterioration was noted.
There was evidence of access to specialist and allied health care services to meet the care needs of residents such as opticians, dentists and chiropody services. Access to palliative care specialists, dietician, physiotherapy and speech and language were also available.
Transfer of information within and between the centre and other healthcare providers was found to be good. Discharge letters for those who had spent time in acute hospital and letters from consultants detailing findings after clinic appointments were seen

The arrangements to meet residents' assessed needs were set out in individual care plans and each resident had some care plans completed, but care plans were not found to be in place for every identified need. Although for the majority of residents, healthcare needs were met, several key areas for improvement were required in the documentation of care given.

Inspectors found that improvements were required to deliver a safe and suitable standard of care and to ensure the clinical care needs of all residents were fully met.
A number of core risk assessment tools to evaluate levels of risk for deterioration were completed but comprehensive assessments were not fully completed for every identified need. These included cognitive impairment and capacity for decision making assessments, pain assessments and restraint assessments.

A strong system to make sure healthcare plans reflected the care delivered and were amended in response to changes in residents' health was not in place. These plans were not being checked regularly to make sure they were detailed enough to maintain or improve a resident's health. The daily nursing progress notes did not always refer to changes in health care plans or changes to treatments or recommendations made by clinicians to give a clear and accurate picture of residents' overall health.
A care plan was not in place for every identified need, for example for respiratory tract infection, medicines or pressure area care for persons on end of life.
Where care plans were in place they were not specific enough to guide staff and manage the needs identified examples included;
-Positive behaviour support plans were not in place to manage behaviours associated

with restlessness and agitation. Inspectors were told that the psychosocial care plans were used to manage these needs. But these did not fully guide staff on the signs to look for as potential triggers to responsive behaviour. These plans also did not guide staff on the type of distraction techniques which could be employed to reduce escalation or of all measures which were known to manage the behaviour and prevent recurrence. A recognised monitoring system called Antecedent, Behaviour and Control (ABC) recording was in place. This system is used by staff to identify what may have caused an inappropriate behaviour, what the actual behaviour was and what was used to reduce or prevent the cause and impact of the behaviour. But inspectors found that these records were not being completed fully and many incidents were not being recorded at all. This meant that the records were not giving an accurate and full picture of the effectiveness of measures used to manage behaviours to inform future care planning and improve the residents overall health and well being. Although in some cases this information was recorded on the nurses daily progress notes, it was again found that these notes did not include all of the measures used or record their effectiveness

-Medications used on an as required basis to manage the behaviours were not referenced in the care plans and a separate care plan for medication management was not in place. This was of concern to inspectors as it was noted that there were some residents for whom a number of different medications were prescribed. Inspectors found that in some cases these medications were frequently administered, this is also referenced under Outcome 9.

-In a sample of nutrition care plans, it was noted that they did not always include reference to the frequency of weight or intake monitoring. Although recommendations of dietician or speech and language therapists were included where residents had been reviewed it was also found that there were some delays in residents being seen by some allied health professionals. In a small sample viewed it had been three weeks since referral to speech and language and dietician and residents had not yet been seen.

- Care Plans to manage end of life care needs were not detailed enough to guide staff and evidence that a high level of care was provided. Examples related to mouth care management where residents with dry and sore mouths did not have specific plans to ensure effective oral care such as frequency of mouth hygiene and hydration; management of breathlessness only advised the continued use of oxygen and did not refer to how to identify symptoms of deterioration or how to manage them. It was also found that most although not all care plans were generic in nature and were not person centred.

- Where residents who were frail or preferred to spend longer periods in bed or in their room, call bells were not always within their reach to enable them summon assistance if required.

Overall it was found that evaluations of care plans together with nursing progress notes and other supporting documentation to evidence the delivery of a high standard of care were not appropriately linked to give a clear and accurate picture of residents' overall health management.

A requirement to improve clinical governance to ensure resident's healthcare needs were appropriately identified, assessed, managed reviewed and implemented is further referenced under Outcome 2 in this report.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

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

Findings:
The centre consisted of 83 single bedrooms and 28 twin bedrooms across four floors. The premises were fully reviewed at the last registration inspection and inspectors were told that no structural changes have taken place since then.

Overall it was found that adequate private and communal space was provided and the design, layout and decor of the centre provided a comfortable environment for residents with appropriate furnishings and areas of diversion and interest.

Residents' bedrooms were personalised with pictures photographs and home furnishings. Call bells were available in resident's bedrooms and communal rooms, grab rails and safe flooring facilitated safe mobilising and the centre was comfortably warm.

The maintenance both internal and external was of a good overall standard. Maintenance staff were observed on site at the centre. They attended to daily reports from staff and upkeep of the premises.

Assistive equipment was in place and available for use and in good working order, service records were up to date and maintenance contracts were in place.

All bedrooms were of sufficient size and layout for the residents, appropriately decorated and with adequate storage for belongings including lockable space for valuables. Privacy screening was in place in twin rooms. All bedrooms had ensuite bathrooms.
The centre as a whole was of a suitable layout and design for the residents and was of sound construction and in a good state of repair. A lift was available centrally for moving between floors. Facilities also included; a hair salon, oratory space and arts and crafts room. There was dining space on each floor of suitable size for the number of residents. There were multiple living rooms and seating space in foyers, with adequate private space in which residents could receive visitors.

There was a well maintained and secured external garden on the ground floor. The

garden was nicely decorated and free of hazards. The area was fenced and secure from unauthorised entry. Staff advised that the area is used for outdoor activities such as barbeques in the summer months. In this external area there was a large sheltered structure which was used as a smoking lounge for residents. This building contained furniture which had been treated to be fire retardant, a television for residents and access to the call bell system.

Judgment:
Compliant

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

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

Findings:
The centre maintained a policy and procedures around recording and managing complaints. The policy and procedures identifies the person in charge as the complaints officer and outlined instructions to different levels of staff in the process and had guidance around recording and following up on verbal complaints as well as written submissions. An appeals process was identified should the outcome of the investigation not be satisfactory. Staff member spoken to by inspectors were clear on how to record complaints and escalate them if required. Residents and their families told inspectors that they were aware of who to go to with any complaints and that they felt comfortable doing so without any negative consequence.

The centre kept a log of complaints received from residents and relatives. The log detailed the date of complaint, the actions and follow-up taken on the matter, the outcome of the complaint and satisfaction status of the complainant. In complaints that required investigation, documentation was kept on meeting minutes and correspondence between the centre and the complainant. Number and status of complaints were summarised for each year, though level of auditing and learning from the trends identified required improvement, as detailed in Outcome 2.

Judgment:
Compliant

Outcome 14: End of Life Care
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity

and autonomy.

Theme:
Person-centred care and support

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

Findings:
A small number of residents were receiving 'end of life' or 'comfort care' during this inspection. A sample of documentation reviewed found that there were arrangements in place for capturing residents' end-of-life preferences in relation to issues such as; spiritual needs or preferences for place of death or funeral arrangements.
A palliative care approach assessment identified where discussions and decisions were taken on the level of medical and care interventions preferred and possible transfer to hospital with family and where appropriate the resident themselves. Although the system in place to capture residents and families preferences and wishes was good, it was not always fully completed. For example aspects regarding religious preferences or concerns expressed were not completed. Also although the form indicated that pain levels were assessed it did not indicate the frequency of assessment to ensure adequate monitoring.

Although palliative care plans were also in place, they were not sufficiently specific to direct the care to be delivered in a holistic manner. Examples included plans in place to manage pain did not reference the signs or symptoms of increased pain, the medicine regime in place to control the symptoms, the effectiveness of the regime or how staff should respond to signs of raised pain levels.
Other care plans in place to manage symptoms associated with for example; fatigue, anxiety or dehydration were also not specific enough to direct and manage care needs. Care plans are also referenced under Outcome 11 where action plans are required.

It was noted that residents family and friends could be facilitated and religious and cultural preferences respected as far as practicable. Access to specialist palliative care services were available where appropriate.

Judgment:
Non Compliant - Moderate

Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

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

No actions were required from the previous inspection.

Findings:
Residents were provided with food and drink at times and in quantities adequate for their needs. Assistance was observed and was offered to residents in a discreet, patient and sensitive manner by all staff.

The dining experience was conducive to conversation. Those residents on modified diets were offered the same choices as people receiving normal diets. A rolling menu was in place to offer a variety of meals to residents.

Most residents took their meals in the dining rooms located on each floor in the centre and tables were appropriately set with cutlery condiments and napkins. Residents spoken with all agreed that the food provided was always tasty hot and appetising. Food was served from a hot plate by a team of staff and was well presented. Modified consistency diets were served appropriately with each element of the meal presented in separate portions on the plate. A list of all special diets required by residents was compiled on foot of the individual residents' reviews and copies were displayed in the main kitchen and in the kitchenettes on each unit.

Drinks such as water, milk, tea and coffee were available. Access to fresh drinking water at all times was available, jugs of water were observed in residents' rooms and water dispensers were available.
Evidence of referral to relevant allied health professional including dietician or speech and language therapists was found and there was a system in place to monitor the intake of residents identified as at risk of malnutrition although inspectors were told no residents were identified as requiring same at the time of inspection.

Judgment:
Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

Findings:
Evidence was found that resident's rights, privacy and dignity was respected with

personal care delivered in their own bedroom or in bathrooms with privacy locks and the right to receive visitors in private. There were no restrictions to visiting in the centre and some residents were observed spending time with family or friends reading newspapers or chatting in their bedrooms.
But information displayed on the walls of some residents' rooms did not fully respect residents rights to privacy and confidentiality. This included aspects of information related to use of incontinence wear and use of restraints or enablers.

Choice was respected and residents were asked if they wished to attend Mass or exercise programmes, control over their daily life was also facilitated in terms of times of rising /returning to bed and whether they wished to stay in their room or spend time with others in the communal rooms. The right to vote in national referenda and elections was facilitated with the centre registered to enable polling.
Access to the internet was also available with skype to help those with relatives abroad to keep in touch.
Staff were observed to interact with residents in a warm and personal manner, using touch eye contact and calm reassuring tones of voice to engage with those who became anxious restless or agitated.
Evidence that residents and relatives were involved and included in decisions about the life of the centre was viewed. Regular meetings were held where residents were consulted about future activities or outings. Feedback and suggestions were recorded with an action plan and timeframes. Records of meetings with relatives were also available. These meetings were facilitated by an external advocate. A programme of varied internal activities and external trips was in place for residents. Information on the day's events and activities was prominently displayed in the centre. A team of three activities coordinators delivered the programme which included both group and one to one activities. Inspectors were told that one to one time was scheduled for residents with more severe dementia or cognitive impairment or who would not participate in the group activities, and that this time was used for sensory stimulation such as providing hand massages. Other dementia relevant activities were included in the programme such as reminiscence and sonas. Although it was noted that records of the amount of time each resident received on a one to one basis each week was not available.
Inspectors noted there was a good emphasis on residents' mental health and well being. This was reflected in the provision of resources available, such as the centre's own mini bus to facilitate individual and group outings.
Feedback from residents and their relatives on the level of consultation with them and access to meaningful activities was generally positive. All those spoken too praised the staff for the cheerful and respectful manner in which they delivered care. Residents said staff were quick to respond to their call bells and regularly enquired if they were OK. Relatives spoken too said they were kept informed of their loved ones condition and could speak to management of they needed too. But some comments identified concerns with the lack of time staff could give to those residents who spent long periods of time in their rooms due to frailty or through choice.

Judgment:
Substantially Compliant

Outcome 17: Residents' clothing and personal property and possessions Adequate space is provided for residents' personal possessions. Residents can

appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:
Person-centred care and support

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

Findings:
There were arrangements in place for regular laundering of linen and clothing and the safe return of clothes to residents.
A policy on residents' personal property was in place and implemented using an inventory on clothes and valuables belonging to residents upon admission. In a sample of those reviewed these were updated.
All clothing was labelled for the laundry and new clothes were added to an initial list by staff.
Adequate space was provided for residents' personal possessions and it was noted that clothing could was stored in a neat and appropriate manner.

Judgment:
Compliant

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
The staff rota was checked and found to be maintained with all staff that worked in the centre identified. A bank of relief staff provided cover to units for planned and unplanned leave. Planned rosters were in place in all units and an actual working rota was maintained electronically. This is also referenced under Outcome 4

The resident profile were frail older persons with a high level of complex needs. 60% of the current resident population were between 80 and 96 years old and were assessed as

being at high/ maximum dependency, meaning that they required the assistance of two staff with most or all of the activities of daily living.
As previously stated under Outcome 2 there had been a high turnover of staff during 2015 with a significant number of senior and experienced staff leaving the centre. This had impacted negatively on the continuity of and standard of care delivered to residents Examples included;

-Replacement of nursing staff with an additional care staff member thereby depleting clinical governance. This was of significant concern on the third floor where, throughout the two days of inspection there were two healthcare assistant staff replacing a qualified nurse. It was also noted that the nurse on night duty on the night preceding the first day of inspection was also replaced by a healthcare assistant. Inspectors were told that the clinical nurse manager provided nursing support to this area, this cover was intermittent and the CNM was still expected to continue to support the units on all other floors. It is acknowledged that the level of complex needs of the resident profile on this unit was not as high as on other floors and no specific risks were identified during the inspection. Inspectors identified that the staff on this floor were more isolated than their colleagues particularly at night.
The ratio of overall day staff to resident ratio was 1:5 and 1:9 on nights which would meet current recommended staffing guidance. But qualified nurse to resident ratio was 1:20 on days and 1:28 on nights. Both of which are considerably outside safe staffing levels recommended by nursing bodies in Ireland and the U.K
-Skill mix of experienced, newly qualified and/or newly hired staff working together resulting in lack of familiarity of the processes and systems in place in the centre such as emergency response systems or resident's responsive behaviours.
-Lack of experience of some of the new management team to provide clear direction and leadership to other grades of staff.
-Lack of experience or familiarity with policies and processes in place to ensure care practices reflect policies and meet residents assessed needs.
An action in relation to staffing resources is included under Outcome 2.
On review of a sample of personnel files they contained all necessary qualifications, references and Garda vetting documentation required by Schedule 2 of the regulations. Confirmation of 2016 registration was kept for all nurses working in the centre. The centre did not avail of agency staff and one volunteer for whom there was evidence of vetting and an agreement of job role and supervision arrangements were in place. Staff appraisals were conducted quarterly and discussed the continuous performance and training of staff.
A training matrix was utilised by human resources to identify gaps and requirements in staff training. Human Resources arrange for staff to attend required upcoming sessions accordingly. All staff were up to date in their mandatory training in protection against elder abuse, fire safety and manual handling. All nurses had received updates on medication management, and kitchen staff in food hygiene/HACCP. Supplementary training was identified for staff around specialised care such as dementia awareness and continence management.
But it was noted that a clinical practice competence development programme would benefit staff going forward.

Judgment:
Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Nuala Rafferty
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	TLC City West
Centre ID:	OSV-0000692
Date of inspection:	09/03/2016
Date of response:	18/04/2016

Requirements

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

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

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Management systems in place did not ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

1. Action Required:
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively

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

monitored.

Please state the actions you have taken or are planning to take:
Several senior nursing management positions have changed and the new appointees have experience and qualifications in gerontology, dementia care as well as management and leadership. All posts will be in place by 31/05/2016. Clinical governance arrangements have been strengthened through a monthly management meeting (effective 12th April 2016) which monitors key performance indicators and quality improvement as well as education and training needs arising for staff at all grades.

Proposed Timescale: 31/05/2016

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All policies were not revised within a three year timeframe, gave sufficient guidance to staff or reflected current best pratice and the regulations.

2. Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
All policies have been reviewed as required.

Proposed Timescale: 29/04/2016

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence that the delivery of suitable and sufficient care to meet residents' needs was not easily available or accessible.

3. Action Required:
Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

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

(A) Planned staffing rosters are prepared monthly in advance and changes are noted as they occur and then entered onto the final roster. The final worked roster is electronically protected and saved and a printed copy is also maintained. The allocation of specific staff to the areas they worked on during each individual shift is also maintained in hard copy.
(B) All resident care records will be audited and reviewed to ensure that they reflect the assessment of need, planned care to be delivered and that resident care records accurately reflect the actual care delivered. These audits will be shared with staff teams to ensure learning and to improve the quality of documentation.
(C) All nursing staff will be supported to document a holistic person centred reflection of care delivered in the progress notes. This support will be in the form of Dementia training (National Programme). TLC Group will have 16 trained trainers by 26th May 2016 and plan to roll out the training to all staff in the coming months. TLC Citywest will have three trainers onsite. Nursing staff will be prioritised for this training during June and July 2016.

Proposed Timescale: (A) Complete (B) 30th June 2016 (C) 30th July 2016

Proposed Timescale: 30/07/2016

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The documentation of alternatives to show that all considerations were explored, in line with national policy as published on the Department of Health website, and found to be unsuitable before a decision was taken to use a form of physical restraint was not always relevant to the restraint being used or fully complete.

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

Please state the actions you have taken or are planning to take:
Training (through the National Dementia programme)will be delivered to all staff nurses initially and then extended to all healthcare assistants on promoting a restraint free environment and positive behaviour support for residents living with dementia.

All nurses will receive training on the importance of recording alternatives to restrictive practice which have been attempted and the need for positive behaviour support to be reflected in all care plans.

Proposed Timescale: 30/06/2016

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policies in place did not include a policy and procedure to give staff guidance and ensure a timely and appropriate response to a medical emergency.

5. Action Required:
Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
A standard operating procedure has been developed and circulated to guide staff in their response to medical emergencies.
In addition, the risk management policy will be revised to include medical emergencies.

Proposed Timescale: 31/05/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Systems in place to identify assess manage and review risks throughout the centre were not sufficiently robust or were not implemented to safeguard all residents.

6. Action Required:
Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
(A)The Risk Management policy will be revised to include identification, recording, investigation and learning from serious incidents or adverse events involving residents including absconsion, medical emergencies.
(B) The monthly analysis of incidents reported and identified risks will be shared with all staff to ensure learning, improve quality of service to residents and to assist in the ongoing management of risks. All incidents will be risk rated and medium and high risks will be reviewed by a multidisciplinary team.
(C) A clinical risk register will be developed and maintained to reflect all current clinical risks
(D) Monthly fire drills will be performed and a report of these drills will be prepared and shared with all staff for learning and improved responses.

Proposed Timescale: (A) 31/05/2016 (B) 30/06/2016 (C) 30/07/2016 (D) 30/05/2016

Proposed Timescale: 30/07/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate and appropriate systems were not in place to ensure all staff were familiar with and competent in all of the procedures to be followed in the case of fire. This included knowledge of each resident's personal evacuation plan and identification of the person on duty who would co-ordinate the evacuation.

7. Action Required:
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
The fire warden on duty on each floor, for each shift is clearly identified in writing and at handover. Housekeeping staff who do not attend handover have been advised of how they can identify this person on each shift. This procedure as well as the location of personal evacuation plans will be re-iterated at fire training for all staff.

Proposed Timescale: 29/04/2016

Outcome 09: Medication Management

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Medications were not always administered within the prescribed time frames and a clear rationale for the administration of as required medications was not available to ensure safe and consistent practice in line with pharmacists' guidance.

8. Action Required:
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

A full pharmacy audit in conjunction with the GP and senior nurse has been completed and each residents prescribed medication has been reviewed. An emphasis was placed on reducing as required medication. Whereas required medication is prescribed, clear rationales for its administration has been outlined in the care plan.

Proposed Timescale: 29/04/2016

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents capacity was not assessed or reviewed prior to their involvement in decisions regarding finances or consent to level of care interventions at end of life stage

9. Action Required:
Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

Please state the actions you have taken or are planning to take:
CSAR forms are requested on all residents prior to pre-assessment and admission. These identify residents' capacity to consent as determined by their consultant.

MMSE is assessed on admission and three monthly thereafter. Any change in cognitive status is reviewed and care plans reviewed as appropriate.

Proposed Timescale: 29/04/2016

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Assessment and care planning were not specific enough to direct the care to be delivered or guide staff on the appropriate use of interventions to consistently manage the identified need.
Complete comprehensive nursing assessments were not carried out for each resident.

10. Action Required:
Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

Please state the actions you have taken or are planning to take:
(A)Education and training for nurses will be provided in respect of assessment and care planning in older people to ensure that appropriate, evidence based and person centred care plans are developed for each resident to guide practice. This support will be in the form of Dementia training (National Programme). TLC Group will have 16 trained trainers by 26th May 2016 and plan to roll out the training to all staff in the coming months. TLC Citywest will have three trainers onsite. Nursing staff will be prioritised for this training during June and July 2016.

(B) All resident care records will be audited and reviewed to ensure that they reflect the assessment of need, planned care to be delivered and that resident care records accurately reflect the actual care delivered. Audits results will be shared with staff to ensure learning and to improve the quality of assessment, care planning, delivery of care and documentation. A system to ensure that post hospitalisation changes for residents is reflected in assessments and care planning, in a timely way will be introduced and audited regularly. Areas such as changes in cognition, capacity for decision making, additional medical needs, changes in behaviour and needs arising as a result, will be prioritised.

Proposed Timescale: (A) 30th July 2016 (B) 30th June 2016

Proposed Timescale: 30/07/2016

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Reviews of care plans did not include a determination of the effectiveness of the plans to manage the needs identified.

11. Action Required:
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

Please state the actions you have taken or are planning to take:
Education and training for nurses will be provided in respect of assessment and care planning as well as evaluation of care plans, in older people, to ensure that appropriate, evidenced based and person centred care plans are developed for each resident to guide practice.

Proposed Timescale: 30/07/2016

Theme:

Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The documentation of care was not sufficiently accurate or appropriately linked to ensure that a high standard of evidence based nursing care was being provided or give a clear and accurate picture of residents' overall health management.

12. Action Required:
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:
(A)Education and training for nurses will be provided in respect of assessment and care planning in older people to ensure that appropriate, evidence based and person centred care plans are developed for each resident to guide practice. This education will be in the form of Dementia training (National Programme). TLC Group will have 16 trained trainers by 26th May 2016 and plan to roll out the training to all staff in the coming months. TLC Citywest will have three trainers onsite. Nursing staff will be prioritised for this training during June and July 2016.

(B) A review of assessments and care plans for each resident will be undertaken to ensure all assessed needs are met and to ensure care planning is reflective of these assessed needs as well as a strong guide to staff for practice. The reviews will be undertaken in conjunction with residents, families and members of the multidisciplinary team.

Proposed Timescale: (A) 30th July 2016 (B) 30th June 2016

Proposed Timescale: 30/07/2016

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents' rights to privacy and dignity were not upheld in relation to the display of confidential information in their rooms.

13. Action Required:
Under Regulation 09(3)(e) you are required to: Ensure that each resident can exercise their civil, political and religious rights.

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

The information referring to residents which was displayed in their rooms has been removed.

Proposed Timescale: 29/04/2016

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Appropriate skill mix to ensure the delivery of safe, suitable and sufficient care to residents' was not in place at all times.

14. Action Required:
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
There have been a number of changes in the management team since the inspection. These will be complete by 30th May 2016.
Efforts continue to recruit additional nursing staff to ensure that planned rosters and appropriate nursing ratios are maintained. 4 staff nurses will be recruited by 30th June 2016. We will continue to review our registered nurse ratio in line with the changing dependency of residents.
In the event that unforeseen staffing challenges emerge, priority will be given to ensure that all floors have a registered nurse present. This will be facilitated by increasing the total number of staff rather than reducing clinical supervision. Resident, staff and family access to the clinical nurse manager and assistant directors of nursing will be maintained to ensure clinical governance is improved.

Proposed Timescale: Ongoing with immediate effect

Proposed Timescale: 29/04/2016