Health Information and Quality Authority
Social Services Inspectorate

Regulatory Monitoring Visit Report
Designated centres for older people

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

Centre name:	Tender Loving Care Centre (TLC)
Centre ID:	0184
Centre address:	Northwood Park Santry Dublin 9
Telephone number:	01-8628080
Fax number:	01-8628090
Email address:	info@tlccentre.ie
Type of centre:	☒ Private ☐ Voluntary ☐ Public
Registered providers:	TLC Centre Ltd
Person in charge:	Dermot McCann
Date of inspection:	25 August 2010
Time inspection took place:	**Start:** 09:30 hrs **Completion:** 19:00 hrs
Lead inspector:	Leone Ewings
Support inspector:	Sonia McCague
Type of inspection:	☐ Announced ☒ Unannounced
Purpose of this inspection visit	☐ Application to vary registration conditions ☐ Notification of a significant incident or event ☐ Notification of a change in circumstance ☐ Information received in relation to a complaint or concern ☒ **Regulatory Monitoring Visit Report**

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 on specific matters arising from a previous inspection to ensure that the action required of the provider has been taken
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Social Services Inspectorate 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 well-being of residents
- **for centres that have not previously been inspected within a specific timeframe, a one-day regulatory monitoring visit may be carried out to focus on key regulatory requirements.**

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 four storey, purpose-built centre with accommodation for up to 128 residents.

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 area. The hairdressing salon, activities room and oratory are located near the reception area.

The dining room is on the ground floor and is open all day with tea/coffee making facilities available for residents and visitors.

There is an enclosed secure garden accessed through the dining room. An external smoking room is available for residents, 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 upper floors has a dining room and a sitting room. Each floor also has a nurses' station and a bathroom with a hydrotherapy bath. The floors are connected by two lifts and two stairwells.

There is car parking available to the front and side of the centre for relatives and other visitors.

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.

Date centre was first established:	2004
Number of residents on the date of inspection	123 (2 residents in hospital)

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	51	15	27	28

Management structure

The providers for this centre are Dr Liam Lacey and Michael Featherston. The Person in Charge is Dermot McCann and he reports to Liz McKeon, director of clinical services, who in turn reports to the provider.

He is supported in his role by two Assistant Directors of nursing and five Clinical Nurse Managers 1 (CNM1) to whom the nursing staff and care assistants report.

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.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1 +2 Assistant Directors	6	19	4	8	3	3*

*Maintenance manager, and two maintenance persons.

Summary of findings from this inspection

This was an unannounced inspection, carried out over one day. The Authority's Chief Inspector of Social Services received a copy of an anonymous complaint made to the Health and Social Care Professional Council. The inspection was informed by this complaint and the issues raised were considered during the inspection.

Prior to the inspection, on receipt of the letter of complaint, the Authority requested a provider led investigation, and this was completed by the provider who involved an independent team of investigators. The provider had carried out an investigation into the written complaint and had produced a report, which was submitted to the Authority. The investigation report had been completed, and reasonable and appropriate measures had been taken during the investigation to safeguard all residents.

The inspection was facilitated in a helpful and welcoming way by the person in charge and staff working at the centre. The inspectors spoke with the residents and relatives, observed practice in the centre and viewed records.

Staff provided care to residents in a competent and respectful manner. However, inspectors found that one member of staff spoken with had difficulty communicating with the inspectors regarding requests for relevant information.

The improvements identified included:

- review pressure ulcer audit and training for pressure ulcer prevention and management
- review the statement of purpose
- reporting and notification of pressure ulcers to the Authority
- provision of maintenance and audit effectiveness
- need to review arrangement for crushing medication

Comments by residents and relatives

Inspectors spoke with a number of the residents throughout the inspection and one group after lunch. Many of the residents had cognitive impairment and were unable to respond at length. However, eight residents spoke to inspectors in detail.

Overall residents expressed satisfaction with the service they received and all praised the staff who they said, delivered care in a pleasant and respectful manner. One resident said staff are "great, they can't do enough for you". Some residents could identify staff by name and knew both the provider and the person in charge. All agreed that the food provided was good and there was plenty of choice.

Residents commented on the daily routine and were happy with activities provided. A word quiz session was ongoing during the inspection. Art classes, film club and exercise classes were held each week. Inspectors spoke to one resident who had attended a computer course held on the ground floor activity room. Another resident told inspectors she liked gardening and did some "outside at the wall".

The residents' representative who had made a written complaint expressed their concerns regarding the quality of the admission for respite, communication with staff, quality of personal care, maintenance of equipment and lost clothing/laundry. These issues were considered as part of the inspection.

Governance

Article 5: Statement of purpose

A statement of purpose was available which largely met all the requirements of the legislation. Specific admission criteria, staffing, the arrangements for review of residents care plans and a complaints procedure which met regulation 39 were included. However, the range of needs the centre was intended to meet needed further detail, particularly relating to the 30 beds on the first floor which were contracted to mental health services. The statement of purpose did not include enough information to accurately reflect the resident profile.

Article 15: Person in charge

Dermot McCann took over as person in charge in February 2010. He is a qualified nurse, with a postgraduate qualification in management and relevant experience working with older persons. The person in charge and the provider confirmed that he worked fulltime (35 hours per week). The roster of the week covering the inspection was reviewed and confirmed that the person in charge was scheduled to work each week Monday to Friday.

Arrangements were in place for an absence of the person in charge. Cover was provided by the assistant directors of nursing, who deputised in his absence. Weekend and out of hours cover at night is provided by a clinical nurse manager. The inspectors reviewed weekly rosters to confirm this. Staff spoken with also confirmed the presence of a clinical nurse manager overnight.

Prior to this unannounced inspection on 24 August 2010, the Authority had received written notification from the provider outlining that the upcoming change in the person in charge. The provider notified the Authority of the name of the proposed person in charge, Imelda Burke, she is due to take up the post on 27 September 2010. Inspectors confirmed this with both the current person in charge and the provider Liam Lacey.

Interim arrangements to cover in the absence of the person in charge until the commencement of Imelda Burke were notified to the authority.

Article 16: Staffing

Direct care staffing levels appeared to be adequate, there were six nurses, two assistant directors of nursing and 19 care assistants on duty for 123 residents on the day of inspection. The rosters confirmed which nurses and carers were rostered for duty. The person in charge told inspectors he reviewed the resident dependencies and kept the staffing levels under continuous review. No agency staff were employed.

One assistant director of nursing worked on the first floor where residents with mental health difficulties were accommodated. He was qualified in mental health and very experienced in this area.

Staffing levels were found to be higher on the first floor, with two staff nurses and seven care assistants working for morning duty until mid afternoon. A clinical nurse manager on duty for the night shift supervised night staff.

Each staff grade were identifiable by their uniform, many residents could identify staff by name. All staff wore name badges identifying their role.

Staff were supported and supervised in the delivery of care by a clinical nurse manager on both day shift and night shifts.

Staff training records were reviewed and showed mandatory training in moving and handling and fire training was provided on an ongoing basis. Training in elder abuse, basic food handling and medication management was also provided. Staff spoken with could discuss the principles of the training received.

Inspectors looked at a sample of six staff files. There was evidence of detailed preparation to meet the requirements of the legislation. The records reviewed contained all the requirements of Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Staff appraisal and personal development reviews were in place to monitor staff performance.

Registration details of all qualified nursing staff were checked and evidence of updated registration with An Bord Altranais was found in the staff files reviewed.

Article 23: Directory of Residents

A directory of residents was maintained in the centre. On review inspectors noted that all residents' details were included and the directory fully met all legislative requirements.

Article 31: Risk Management Procedures

A detailed policy on falls prevention was in place and included aims, criteria, guidelines for action and environmental hazard identification. A risk management committee to review, audit and manage risks was in place and included the physiotherapist. Inspectors found a good standard of reporting and awareness of staff of accidents and incidents.

Quarterly notifications from February to April 2010 and from May 2010 to end of July 2010 from the person in charge were reviewed prior to inspection.

A monthly falls audit was in place. The inspector reviewed records of these audits and evidence of review and recommendations of action to be taken was found. For example, one action required was for a medical review including a review of medication. Inspectors reviewed one resident's record and found the actions had been completed following the review process.

An emergency plan detailing actions to be taken in the event of evacuation, resources, specific contact details and arrangements in place to manage such an emergency was available. Staff spoken with were aware of the arrangements in place in the event of any emergency occurring.

Article 39: Complaints

A comprehensive complaints policy and procedure that complied with all regulatory requirements was available and prominently displayed at the reception area. The policy was also included in the centre's statement of purpose. Inspectors saw comment cards and boxes prominently placed on the walls inviting feedback on service provision.

A record of all complaints was maintained in the centre. All verbal and written complaints were recorded. The record included details of actions taken, follow up outcome and the satisfaction or otherwise of the complainant. On review of the complaints record, inspectors found that all complaints were investigated and responded to in an appropriate and timely manner. The most recent complaint received by the person in charge was regarding the flooring at the entrance foyer, this issue had been resolved satisfactorily.

Information received by the Authority regarding a written complaint following a short term respite admission organised by the Health Services Executive (HSE), had not been investigated by the provider. The provider and the person in charge confirmed to inspectors that they were not in receipt of any current complaint from the HSE or the resident or their representative. However, the provider told inspectors that he would like an opportunity to see the complaint and address the issues raised, and would raise the issue with the HSE.

Article 36: Notification of incidents

The person in charge had notified the Authority of a number of serious incidents as required by Article 36 in a timely and complete fashion, including quarterly notifications. However, the inspectors noted a failure to accurately document and audit pressure ulcer prevalence at the centre. Notifications regarding pressure ulcers grade 2 and above had not been received by the Authority.

Inspectors reviewed a wound care audit tool completed by a clinical nurse manager; one resident with a grade 3 pressure ulcer was not documented in this report. A further resident with a grade 4 pressure ulcer did not have the grading documented on the report, and was nursed on an overlay mattress, not in line with the centres' policy on pressure ulcer treatment, or contemporary evidence-based best practice.

Inspectors reviewed training records and found no evidence of staff training in pressure ulcer prevention and management.

Resident Care

Article 9: Health Care

The general practitioners (GPs) who visit the centre come from a practice in Beaumont. One GP comes in every day Monday to Friday. An out-of-hours medical service is available. A physiotherapist works full time at the centre Monday to Friday, and assists with mobility assessments and review, at no extra charge.

The older persons outreach team from the local acute hospital visits a small number of residents who had been admitted or seen in accident or emergency. Inspectors saw reports in residents' records of recent review following an admission.

Thirty beds on the first floor were allocated to admissions from psychiatry of old age consultants. All residents were assessed prior to admission and were subsequently followed up and reviewed on a regular basis. A community psychiatric nurse (CPN) visits every Tuesday and staff meet to discuss residents who need review by the visiting psychiatrist on Wednesday. However, a record of the CPN review with staff nurses was not found to be kept in the residents' record.

The staff nurse told the inspector that occupational therapy, speech and language therapy were accessible if a resident requires theses services, through the HSE or privately for a fee. The chiropodist visits regularly. The inspector saw evidence of referral in the residents' records to peripatetic services, and ongoing review.

A number of low dependency residents sat together after their meal and told the inspector they felt well cared for and safe at the centre.

Article 33: Ordering, Prescribing, Storing and Administration of Medicines

Overall inspectors observed safe practice in the administration of medications. Medication management was supported by specific policies and procedures, which were reflected in practice. A detailed medication management policy had been issued recently on 11 August 2010, in collaboration with an external nursing consultant. Controlled drugs were checked at the end of each shift and records confirmed this.

Medication audits were in place and the most recent took place in April 2010. The clinical nurse manager monitors the ordering, storage and return of medications on a monthly basis. Medication errors were recorded and managed by documenting an incident record.

However, a number of medications were found to be crushed, this was not indicated on the medication administration chart by GP. Drugs trolleys were found to be locked and chained to the wall at the nurses' station. However, medication administration charts were seen by inspectors to be left on top of the trolley, and were accessible on the ground floor corridor nurses station to visitors and other residents.

Article 6: General Welfare and Protection

There was a policy on elder abuse. Senior management personnel provided training and the training tracker provided to inspectors confirmed that prevention, detection and responding to elder abuse training had been provided for all staff.

Staff spoken with were knowledgeable about what constitutes abuse and reporting procedures.

The person in charge was clear about his role and responsibilities in adult protection.

Article 20: Food and nutrition

Residents were provided with nutritional meals that offered them choice and variety. They appeared well nourished and hydrated. Staff were aware of residents dietary needs, their likes and dislikes and access to HSE dietician was available. Inspectors spoke to nursing staff and they explained that the malnutrition universal screening tool (MUST) was used for each resident, and referrals were made based on the MUST tool, clinical review and knowledge of the residents eating habits.

The dining rooms were clean and tables attractively set. The menu was displayed on each table in the dining rooms. The atmosphere was relaxed and choice was offered to all residents. Independent dining was encouraged with regard to drinks and accompaniments to each meal. Visitors were not excluded at mealtimes and could assist their relative if required. They were also encouraged to use the facilities for tea, coffee, soft drinks and snacks with the residents they were visiting. Inspectors saw small groups visiting and using the dining room outside mealtimes.

An inspector examined records of previous menus, this showed that the range of choices presented were normal practice every day. The menus were varied, offered choice and were nutritional. Meals were provided for residents diagnosed as diabetic or requiring soft or modified meals in an appropriate manner. A private fine dining room was available in a room off the ground floor day room; this room could be booked by any resident for a special family occasion and was used to celebrate Christmas and birthdays or any other times.

Jugs and water glasses were observed on residents bedside lockers, and drinks were available in communal areas for residents to access independently. Staff were also observed offering drinks to residents at intervals during the inspection.

Environment

Article 19: Premises

Overall, the centre was found to be clean, bright, sufficiently ventilated and well organised. There was a maintenance team employed and the inspector observed checks being carried out.

A household cleaning team are employed and the staff member who spoke with inspectors was knowledgeable regarding infection control practices. There were cleaning schedules in place. Maintenance of moving and handling equipment was up to date and a detailed contract was in place with an external maintenance provider to maintain beds, mattresses and specialist equipment.

The communal areas and bedrooms were homely and domestic in character. The dining rooms were spacious and bright. Carpets were used for corridors and some of the bedrooms. However, inspectors found one twin room on the third floor with a damaged carpet, which was foul-smelling. The person in charge told the inspector that the carpets were cleaned regularly by the maintenance staff owing to repeated soiling from urine and this carpet required replacement. A number of small burn marks to the carpet were also found. A list of carpets cleaned was reviewed in the maintenance reports. Some maintenance reports were not found to be responded to in a timely manner and the system of reporting requires review.

Privacy locks were in place in most of the bathrooms and toilets. However, the privacy lock on the third floor shower room was not working and communal toiletries and creams were found to be stored on a shelf in this room.

Each resident did not have access to a lockable storage space in his or her room.
The sluice room on the third floor did not have a separate wash hand basin in place, the room was cluttered and poorly organised.

Article 32: Fire Precautions and records

Fire policies and procedures were reviewed by inspectors and were found to meet legislative requirements. Fire records indicated that fire safety training took place regularly and fire escape routes and fire fighting equipment was checked in line with best practice.

All corridors were zoned for fire safety purposes, good directional signage, appropriate fire procedures and exit directions were available on all corridors.

Fire safety systems and procedures were found to be in place. However, when some staff told inspectors about the procedures to be followed in the event of fire, the telephones at the nurses' stations used to contact reception were not working properly on three of the upper floors, and had not been for a number of days. The procedure then instructed staff to go to reception if they could not get through, as it is covered 24 hours a day, with a night porter at night. The provider told inspectors he was aware of the fault with the telephones and was trying to address it.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider, the person in charge, the assistant directors of nursing and maintenance manager to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:

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

24 September 2010

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report

Centre:	Tender Loving Care Centre (Santry)
Centre ID:	0184
Date of inspection:	25 August 2010
Date of response:	11 October 2010

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:

The statement of purpose does not include all of the information and detail required.

Action required:

Amend the statement to incorporate all matters as listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Action required:

Ensure the statement of purpose accurately describes the service provided, specific admission criteria, the type of nursing care to be provided, the arrangements for review of residents care plans and a complaints procedure, which meets regulation 39.

Reference: Health Act, 2007 Regulation 5: Statement of Purpose Standard 28: Purpose and Function	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The statement of purpose has been amended to provide ▪ information on specific admission criteria ▪ the type of nursing care provided ▪ the time frame for review of care plans ▪ The time frame for review of complaint	Completed September 2010

2.The provider has failed to comply with a regulatory requirement in the following respect: A record of the weekly meeting with the community psychiatric nurse was not kept in the resident's records.	
Action required: Review record keeping following the weekly meeting with the community psychiatric nurse and ensure a record of this intervention and any follow up is kept in each resident's record.	
Reference: Health Act, 2007 Regulation 25: Medical Records Standard 13: Healthcare	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Protocol has been put in place to facilitate registered general nurse / clinical nurse manager who accompanies community psychiatric nurse on clinical rounds to record date time and outcome of visit. This entry will be highlighted in nursing care plan. The visit will also be recorded in the multi-disciplinary file.	Completed 4 October 2010

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

The premises was not kept in a good state of repair and maintenance requirements reported by staff and residents were not responded to in a timely manner.

Action required:

Review the maintenance requests reported by staff and residents and ensure a timely response is made to all requests.

Investigate and repair telephone fault to/from all floors to reception.

Replace flooring in room 316.

Repair or replace privacy lock in shower room on third floor.

Provide separate hand washing facilities in the sluice room on the third floor.

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:	
1. New maintenance form in place with tracking systems for completion of task. Reviewed daily by maintenance supervisor. Sample form attached.	Completed September 2010
2. All telephones are in good working order. Invoice attached for repairs identified in report.	Completed 2 September 2010
3. Flooring in room 316, replaced.	Completed September 2010
4. The privacy lock in the assisted shower room on third floor as identified in the report has been repaired. Maintenance form on repair attached.	Completed September 2010
5. A hand basin with hot and cold water has been fitted in the sluice room on the third floor.	Completed October 2010

4.The person in charge has failed to comply with a regulatory requirement in the following respect:

Medication administration charts with confidential information, were accessible at the ground floor nurses station on top of the drugs trolley.

Action required:

Review practice of storing medication administration charts on top of drugs trolley, and find an alternative confidential place to store the charts.

Reference:

Health Act, 2007
Regulation 22: Maintenance of Records
Standard 4: Privacy and Dignity

Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response: Medication administration charts, when not in use are now stored in the nurses' station where there is no access for the clients or public.	Completed September 2010

5.The person in charge has failed to comply with a regulatory requirement in the following respect:

Residents were receiving medication which was crushed, without it being prescribed by the general practitioner as crushed.

Action required:

Review practice of administering crushed medication without specific prescribed instructions that it is safe to do so.

Reference:

Health Act, 2007
Regulation 25: Medical Records
Standard 14: Medication Management

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

Provider's response: A meeting took place with director of nursing and pharmacist on 1 October 2010 to determine technology required to facilitate inclusion of section into current prescription sheet, thus enabling instructions by medical officer for crushing medications when required. Plan formulated and first draft expected on 14 October 2010. A meeting is scheduled to take place with the medical officers attending TLC, director of nursing, Dr Lacey, Liz Mc Keon, and the pharmaceutical company, at which processes will be reviewed	14 October 2010 18 October 2010

6. The person in charge has failed to comply with a regulatory requirement in the following respect: The pressure ulcer audit completed by clinical nurse managers in use was not accurately completed and did not include all residents with pressure ulcers.
There was no evidence of staff receiving training or updates on pressure ulcer prevention, and management including grading of pressure ulcers.
Action required: Review pressure ulcer audit document in use, and ensure all staff have full training in completion and analysis of results.
Provide pressure ulcer prevention and management training for all staff involved with direct care.
Ensure the person in charge notifies the Authority of the prevalence or admission of any resident with pressure ulcers grade 2 or above in compliance with article 36 of the regulations.
Reference: Health Act, 2007 Regulation 17: Training and Staff Development Standard 10: Assessment

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

Provider's response: A review of the clinical audit systems is currently in process. Audit tools are being reviewed with clinical nurse managers. Liz McKeon, and the Director of Nursing. Daily care planning documentation of all wounds, and weekly notification currently exist this is to be complimented by monthly audits. Education on wound management policy and care planning continues. Wound management policy re–launched on all wards week 3 October 2010. Structured education on training and updates on pressure ulcer prevention and management including grading of pressure ulcers is being arranged Wound care committee meetings convene monthly.	 Work in progress next meeting scheduled 4 and 6 October 2010 Ongoing 2010 14 October 2010 6 October 2010

Recommendations

These recommendations are taken from the best practice described in the *National Quality Standards for Residential Care Settings for Older People in Ireland* and the registered provider should consider them as a way of improving the service.

Standard	Best practice recommendations
Standard 25 Physical Environment	Each resident does not have access to lockable storage space in their rooms. Provider's response: A review of lockable storage space in all rooms is in process. Maintenance will fit locks in a project management process this will commence in October 2010. It is planned to replace furnishing in some rooms. The new equipment will have lockable areas.

Any comments the provider may wish to make:

Provider's response:

HIQA inspecting Ms. Leone Ewings and Ms. Sonia McCague attended at TLC Centre Santry for an unannounced regulatory monitoring visit on the 25th August 2010.

The inspection was carried out with the normal amount of anxiety and anticipation within our staff members. This was our first experience of inspection at the TLC Centre, Santry by HIQA. Both inspectors were courteous and efficient and our staff in general were able to respond in a positive way, and interaction with the inspectors did not cause friction nor was it intimidating.

Overall we were happy with the outcome and we acknowledge that some improvements are required as reflected in our action plan and we have been able to attend to all of these issues without exception and they have all been acted upon.

Finally I would like to take this opportunity to thank all members of our staff for the continued dedication they show to the residents of TLC Centre, Santry. Their ability in affording our residents, the opportunity to live in a safe environment, which they call home with dignity and respect, is to be commended.

It is part of our ongoing mission to continue to deliver a five star service to our residents. Remember that the TLC Centre is a place for living. All our standards are set according to best practice and it is our aim to perform above the regulatory standards set down in the 2007 Health Act.

Management had not been informed of the complaint or its content on the date of inspection. Management received the documentation pertaining to the complaint on 27 October 2010 in a correspondence from the Health Services Executive. A full investigation is currently taking place with an invitation extended to the complainant to visit and discuss her concerns.

Yours sincerely,

Provider's name: Liam Lacey TLC Group
Date: 7 October 2010