<table>
<thead>
<tr>
<th>Centre name:</th>
<th>The Tower Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0000110</td>
</tr>
<tr>
<td>Centre address:</td>
<td>94/ 95 Cappaghmore, Clondalkin, Dublin 22.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 457 4209</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:clondalkinnursinghome@live.com">clondalkinnursinghome@live.com</a></td>
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<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<tr>
<td>Registered provider:</td>
<td>Clondalkin Nursing Home Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Patricia Robinson</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Aine Jones and Hazel Nangle</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Deirdre Byrne</td>
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<tr>
<td>Support inspector(s):</td>
<td>Maeve O'Sullivan</td>
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<tr>
<td>Type of inspection</td>
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<tr>
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<td>19</td>
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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 judgements 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 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.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 28 January 2014 08:00  To: 28 January 2014 20:00

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

| Outcome 02: Contract for the Provision of Services |
| Outcome 03: Suitable Person in Charge               |
| Outcome 04: Records and documentation to be kept at a designated centre |
| Outcome 06: Safeguarding and Safety                 |
| Outcome 07: Health and Safety and Risk Management  |
| Outcome 08: Medication Management                   |
| Outcome 10: Reviewing and improving the quality and safety of care |
| Outcome 11: Health and Social Care Needs            |
| Outcome 12: Safe and Suitable Premises              |
| Outcome 13: Complaints procedures                   |
| Outcome 18: Suitable Staffing                       |

Summary of findings from this inspection
This monitoring inspection was unannounced and took place over one day. As part of the monitoring inspection the inspectors met with residents, relatives, staff members, and the two persons in charge. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

The previous inspection had taken place on the 11 June 2013, and a number of areas of non compliances were identified with the Health Act (Care and Welfare of Residents in Designated Centres for Older People) Regulations (as amended). The provider had also been required to take immediate action for a number of significant risks identified at that time.

Inspectors met the two nurses who shared the post of person in charge. There was evidence of poor leadership and governance and inspectors had significant concerns with the overall management of the centre. Inspectors found that there was an overall failure on the part the registered provider and persons in charge to adhere to the requirements of the Regulations.
A significant number of non compliances were identified at this inspection. These included the management of residents’ health care needs and care plan documentation. Inspectors also identified deficits in relation to fire safety and the protection of vulnerable adults in terms of residents’ finances. Additionally, there were improvements required in the overall review and quality of the care and services provided to residents. Other areas for improvement included aspects of the premises, storage for equipment, opportunities for residents to participate in activities, and appropriate supervision of staff. These items are discussed in the body of the report and are included in the Action Plan at the end of this report.

Inspectors were also concerned that areas of non compliance identified on previous inspections remained unresolved. In this inspection the 10 areas of non compliance found at the previous inspection of June 2013 were followed up. Of these 10 actions three had been completed, two partially completed and five were not completed.

The three completed actions were:

- medication management
- provision of sluicing equipment
- staff documentation.

The two actions partially completed were in relation to:

- the maintenance of records for residents
- provision of high standard of nursing care

The five actions not completed were:

- the refurbishment works in the laundry and staff facilities
- aspects of the centre were not maintained to a suitable standard
- the dining room was not large enough for all residents
- review of the quality and safety of care provided to residents
- care planning documentation.

Prior to the inspection, information was received by the Authority. This was reviewed as part of the inspection, and is detailed under outcome 13 of the report.
Section 41(1)(c) of the Health Act 2007 Compliance with 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.

**Outcome 02: Contract for the Provision of Services**

*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:**
Leadership, Governance and Management

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
There were improvements required in the contract of care provided to residents.

Inspectors reviewed a sample of residents care files, and found that a written contract of care was in place and developed within the mandatory timeframe. It set out the services to be provided and the fees. However, improvements were identified. For example, contracts were not consistently agreed between the residents and the registered provider, but with the previous provider of the centre.

**Outcome 03: Suitable Person in Charge**

*The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.*

**Theme:**
Leadership, Governance and Management

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
Inspectors had concerns regarding the clinical governance and leadership in the centre. Two suitably qualified nurses shared the full time post of person in charge. They shared the post by working two to three days alternating each week, and on call at weekends. Both had the relevant experience required by the Regulations and had attended all mandatory training. On the day of inspection, both nurses were on duty. The second
nurse came off leave to be available to the inspectors. They meet with the nominated provider formally every two weeks and, the minutes of which were seen by inspectors

The persons in charge work side by side by on different days of the week. They were in regular contact on a daily basis by phone call and held informal meetings with each other. However, inspectors were not satisfied that there was a clearly defined management structure which identified the lines of authority and accountability in the centre. For example, the shared roles and responsibilities of persons in charge was not formally outlined to ensure their direct lines of authority and accountability. There were weaknesses in the knowledge of the persons in charge of their responsibilities. For example, the documentation of residents' care plans, the management of aspects of residents' health care, reviewing the quality and safety of care to residents and the management of complaints. These deficits had been identified at previous inspections.

Inspectors were not satisfied that the persons in charge demonstrated the competencies required to ensure the continued governance, operational management and administration of the centre.

In a discussion with both persons in charge during the inspection, they gave a commitment to address the issues of non compliance raised and ensure that appropriate arrangements would be put in place. Following the inspection an outline of the roles and responsibilities of the persons in charge was submitted to the Authority.

The persons in charge deputised for each other, and had on call arrangements in place to cover each other during either of their absences

**Outcome 04: Records and documentation to be kept at a designated centre**

*The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) 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 2009 (as amended).*

**Theme:**
Leadership, Governance and Management

**Judgement:**
Non Compliant - Moderate

**Outstanding requirement(s) from previous inspection:**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
Inspectors were not satisfied that complete and accurate records for residents were
maintained and improvements were required in a number of areas.

Inspectors found that medical records and other records relating to residents and staff were maintained. An action from the previous inspection was partially completed and records were now maintained in an easy to retrieve manner. However, records relating to residents were not consistently kept up-to-date. For example, there were some incomplete care assessments, and gaps in documentation. Additionally, records relating to residents were not stored in a secure manner. For example, care plans were not secured at times during the day.

The resident’s guide reviewed was not in line with the requirements of the Regulations for example, it did not contain a summary of the complaints procedures or the terms and conditions of the service. Although inspectors saw that up-to-date insurance cover was in place, it could not be confirmed if adequate cover was provided in regard to accidents and incidents and loss or damage to residents' personal property.

There was a register of residents maintained however, it did not fully meet the requirements of the Regulations. For example, the gender of residents was not included. There were centre-specific operational procedures to inform practice and provide some guidance to staff. Inspectors found that staff members were sufficiently knowledgeable regarding these operational policies.

### Outcome 06: 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.*

<table>
<thead>
<tr>
<th>Theme:</th>
<th>Safe Care and Support</th>
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<tr>
<td>Judgement:</td>
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### Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

### Findings:
Inspectors were not satisfied that the provider had ensured the systems in place to protect residents from being harmed or from suffering abuse were sufficiently robust.

There was a policy on the safeguarding of residents finances which guided practice. However, it was not implemented in practice. Inspectors were concerned that cash withdrawals from residents personal accounts held in safekeeping in the centre were not carried out in a transparent and accountable manner or in line with procedures. For example, inspectors read records of withdrawals that had been carried out by the person in charge and the provider from money that was held in safekeeping for one residents. There was no evidence if consent or authorisation had been given by the resident and the money had not been replaced on one occasion. This was brought to
the attention of the persons in charge who said it should not have happened. Inspectors were later advised that the money had been returned to the residents' account. The provider was also required by the Authority to carry out an investigation into the matter.

Inspectors read a policy on the protection, detection and response to abuse, and found it provided guidance to staff. Staff training records seen by inspectors confirmed most staff had received up-to-date training. However, two staff had not had attended adult protection training. One of the persons in charge later confirmed that training would be provided before the end of February 2014. Staff interviewed by inspectors were knowledgeable of the types of abuse, and who they would report concerns to.

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**Outcome 07: Health and Safety and Risk Management**

*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**
Safe Care and Support

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
There were systems in place to ensure that the health and safety of residents, staff and visitors was promoted and protected. However, improvements were required in the management of fire safety and risk management.

Inspectors found precautions were in place to manage the risk of fire however, improvements were identified. For example, a large gap was identified between two double fire doors on the first floor that may pose a risk in the event of a fire. This was brought to the attention of the persons in charge who informed inspectors it would be addressed immediately. Inspectors read records that confirmed most staff had up-to-date training. It was noted that one staff member who worked as a relief staff had not completed fire training, this was discussed with the person in charge who later confirmed future training dates for the staff member. Staff were familiar with the fire evacuation procedures for the centre. Inspectors was satisfied that all other fire arrangements were in line with the Regulations and promoted residents, staff and visitors safety.

There were health and safety and risk management policies in place which met the requirements of the Regulations. There was evidence that risks were identified and assessed. A risk register was seen, and risks identified at the last inspection had been addressed. For example, the new laundry room and staff facilities had a risk assessment completed.
A health and safety committee met every few months, and reviewed the risk register. A risk management audit had been completed however, as reported in outcome 10, there was no evidence of the action taken to address the findings, or who was responsible. A full-time maintenance man was based in the centre and carried out regular checks to review fire safety precautions and maintenance checks.

Inspectors were satisfied that the policies and procedures on infection control were in place. There were comprehensive procedures in place. Staff had completed training in infection control. Disposable aprons, gloves and hand gel dispensers were available throughout the centre.

There were arrangements in place to manage adverse events or serious incidents involving residents. Records read confirmed staff had up-to-date mandatory training. There was safe flooring provided. There were grab-rails in circulation areas. Handrails were provided in toilets, bath and shower areas. However, one handrail in a first floor shower room was loose and could pose a risk if a resident were to use it.

A comprehensive emergency plan was read by inspectors which outlined the arrangements to be followed in the event of a fire, flood or gas leak.

### Outcome 08: Medication Management

*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**
Safe Care and Support

**Judgement:**
Compliant

**Outstanding requirement(s) from previous inspection:**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Inspectors were satisfied that residents’ were protected by the medication management policies and procedures for the centre.

The medication policy reviewed by inspectors was comprehensive and guided practices. Inspectors reviewed a sample of residents’ prescription and administration sheets. Overall, good practices were found and medications administered were individually signed by the administering staff. Actions from the previous inspection were completed. The person in charge was in discussions with the pharmacy to introduce a new administration sheet which was shown to inspectors.

Inspectors found that regular reviews of medication practices were undertaken, and there was evidence of three-monthly medication reviews by a GP which were recorded in residents' medical notes. Where errors had occurred an investigation was carried out...
along with details of the action taken and learning for staff. There were weekly medication audits and these were discussed at nursing and management meetings.

There were procedures in place for the storage and management of medications that required strict control measures (MDAs). Medications that needed temperature controls were safely stored in a locked refrigerator, with adequate controls measures in place.

All nursing staff had undertaken medication management training in June 2013. Inspectors spoke to staff and found them to be knowledgeable of the medication administration procedure.

**Outcome 10: Reviewing and improving the quality and safety of care**
*The quality of care and experience of the residents are monitored and developed on an ongoing basis.*

**Theme:**
Effective Care and Support

**Judgement:**
Non Compliant - Moderate

**Outstanding requirement(s) from previous inspection:**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
Inspectors found the system in place to monitor and review the safety and quality of care of residents in the centre was insufficiently robust to effect change and drive improvement. This had been an action identified at previous inspections and was not completed at this inspection.

The persons in charge showed inspectors records of data collected and reviewed on an ongoing basis. It mostly related to two key performance indicators (KPI), restraint and falls. Good practice was evident in relation to analysis and taking appropriate action for these two KPIs. However, there was no evidence of continued improvements or changes brought about to enhance the overall quality and safety of care. Additionally, there were audits undertaken for other areas such as risk management procedures, complaints and infection control and findings were recorded. However, they were one-off audits and the findings were not used to affect change.

Inspectors found residents were not consulted with in reviews and audits, and staff were not informed of the findings for learning purposes. Furthermore there was no formal plan in place to review other key performance indicators.
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. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. 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

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Improvements were required in the overall quality and review of care plans for residents assessed needs, the documentation of care plans, consultation with residents and opportunities for social engagement.

Arrangements to meet residents’ assessed needs were set out in care plans based on a range of assessments which had been carried out at regular intervals. However, in many cases the care plans did not guide the care to be delivered to residents. For example, in relation to falls, stoma care and activities. There was inconsistent evidence that the residents and where appropriate the next of kin had been consulted in relation to the development of care plans. Where care plans were reviewed they were not formally carried out and the quality of the review was not effective. For example, apart from a nurses signature and date no other information on the residents care was provided. This was an action at the last inspection and had not been addressed.

Inspectors found most of the actions relating to the management of falls from the last inspection had been completed, however an area of improvement was identified. A falls policy was in place that provided direction to staff. It included guidance on the post fall procedures to be followed. Neurological observations were completed after a fall and records read by inspectors confirmed this. An accident/incident form was completed following each fall. However, care plans were not consistently updated with any further interventions to be put in place to prevent similar falls occurring in the future.

Inspectors found inconsistent practices in place for residents with behaviours that challenged resulting in residents’ needs not being met. While a policy was in place to guide practice, it was not properly implemented in practice to ensure consistency of care for all residents. For example, not all residents' needs were set out in care plans to guide staff in the consistent care to be provided. Additionally, behavioural monitoring charts reviewed had not been fully completed and did not provide sufficient information.
to guide care to be delivered.

There was a policy on the use restraint which provided direction to staff and inspectors found good practices in the management of restraint. There was evidence of regular assessment and consideration of the alternatives. Improvements were found since the previous inspection, and actions had been addressed. Bed rails and lap belts were in use for a number of residents. There was evidence of regular assessment and consideration of the alternatives. Care plans were developed to guide the care to be delivered. Inspectors read records of consultation with residents or their next of kin, and records confirmed restraints were monitored on an ongoing basis.

Inspectors found good practices in the management of wound care. There were records of wound assessments and wound dressing, and care plan in place to guide care for each wound. Staff were familiar with wound care procedures.

Residents' healthcare needs were supported by good access to of GP services and an out-of-hours GP service was available. Inspectors found health care staff were knowledgeable of their health care needs.

The residents had access to a range of allied health professionals for example, dietician, speech and language therapist and psychiatric services. Letters of referrals and appointments were seen on residents' files. The staff had a good understanding of the care needs of the residents.

Inspectors found the social care needs of residents were not fully met. There was a programme of activities displayed in the reception area with the daily activities provided for residents. Inspectors noted activities took place once a day for two or three hours, and consisted mostly of group activities such as bingo, and on other days, music sessions or the rosary. A health care assistant (HCA) was allocated a number of hours a day to facilitate activities for residents. However, inspectors did not observe any activities taking place during the day of inspection, apart from the rosary in the evening. Inspectors observed that residents spent large parts of their day in the sitting room, watching television or chatting to staff. Some residents sat alone, and a small number stayed in their room. Residents told inspectors there was very little to do, and they would like to do more. This was also reported by some staff and relatives on the day of inspection.

**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. There is appropriate equipment for use by residents or staff which is maintained in good working order.*

**Theme:**
Effective Care and Support

**Judgement:**
Non Compliant - Major
Outstanding requirement(s) from previous inspection:
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Inspectors found that the physical environment in the Tower Nursing Home did not meet residents' needs and the requirements of the Regulations. Furthermore, improvements are required to the premises in order to comply with 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 by 1 July 2015.

The person in charge advised inspectors that there is a definitive plan in place to address the deficits in the premises. The building and refurbishment works were expected to commence in the Summer of 2014 however, the plans were not costed and planning permission had not yet been obtained.

A laundry and staff facility that had been put in place to address an action from the previous inspection however, the wall of the staff facilities and floor of the laundry were not been provided with a suitable finish.

The person in charge said that many of the outstanding issues with the premises identified at the previous inspection would be addressed by the planned extension and renovation project.

The deficits in the premises include the following:

- The premises in general was in a poor state of repair in places and in need of refurbishment
- There was poor lighting in the centre which resulted in shadows and darkened areas
- There was inadequate storage space in the centre and inspectors observed equipment such as chairs and hoists being stored in the corridors, which posed potential risks
- There was inadequate dining space for residents.

In addition to the deficits identified above, there were two three-bedded rooms. Inspectors visited one of the three bedrooms. There was adequate screening between beds and space for a locker between beds. The person in charge informed the inspectors that she was aware of requirements in the Authority's Standards to be put in place in relation to bedroom occupancy by 2015 and confirmed that the building and refurbishment work would address this requirement.

A number of residents' bedrooms were visited. They were comfortable, homely and personalised by residents with their own items and furniture. Each bed was provided with a functioning call bell, and each room had its own television.

Appropriate assistive equipment was provided to meet residents’ needs such as hoists, seating, specialised beds and mattresses. Inspectors viewed the servicing and
maintenance records for equipment such as hoists and the chair lift and found they were up to date.

Inspectors found an action from the previous inspection was completed and the sluice facilities were satisfactory and met the requirements in the Authority's Standards.

**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

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
Inspectors found the provider and persons in charge had suitable arrangements in place for the management of complaints however, improvements were required in the overall management of complaints and implementation of the complaints policy.

There was a centre-specific policy and procedure in place which had been drawn up in line with the requirements of the Regulations. However, it was not fully implemented in practice. For example, although one of the persons in charge was the nominated complaints officer, the nominated provider was also investigating complaints. The nominated person who oversaw complaints were responded to and reported was also the nominated provider. Furthermore, there was inconsistent reporting and maintenance of records of complaints made in the centre. For example, an ongoing complaint investigation was discussed with the persons in charge but there was no record of it on file. Inspectors read a number of other complaints and found that some complaints had not been reported to the complaints officer.

Residents and relatives said that they felt comfortable making a complaint and said that they would go to a senior nurse or one of the persons in charge if they had a problem.
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.

Theme:
Workforce

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Inspectors found the recruitment of staff was in line with the Regulations and there was an appropriate staff skill mix on the day of inspection. However, improvements were required in the ensuring that the staff skill mix was adequate in the event of an emergency, and staff received up-to-date mandatory training and appropriate supervision.

Inspectors saw that staff rotas were maintained and a nurse was present in the centre 24 hours a day. At the time of inspection there was sufficient staff to meet the assessed needs of residents. Contingency measures were in place to cover staff on annual or sick leave. However, inspectors were not satisfied that in the event of an emergency that they staff numbers were adequate. For example, one of the persons in charge had to cover a number of night shifts due to staff nurses not being able to work at short notice.

Records confirmed most staff had up-to-date mandatory training. However, gaps were identified. For example, a number of staff had not received training in elder abuse and fire safety as outlined in outcomes 6 and 7. There was evidence that staff had been provided with additional training since the last inspection, such as training in behaviours that challenged and food and nutrition. However, there was no plan or a system in place to review training needs or to provide training for staff based on residents identified needs. There was no formal system in place to supervise staff. Staff spoken to were familiar with the centres policies and procedures.

There was a written operational staff recruitment policy in place. A sample of staff files was reviewed and inspectors noted that the required documentation was in place in line with the requirements of Schedule 2 of the Regulations. This had been an action at the previous inspection and was completed. An Bord Altranais agus Cnáimhseachais na hÉireann registration numbers for all nursing staff were in place and up-to-date.
Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

Report Compiled by:

Deirdre Byrne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

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<tr>
<td>Date of inspection:</td>
<td>28/01/2014</td>
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<tr>
<td>Date of response:</td>
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Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure Compliance with 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.

Outcome 02: Contract for the Provision of Services

**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The contract of care for residents were not consistently between the resident and the registered provider.

**Action Required:**
Under Regulation 28 (1) you are required to: Agree a contract with each resident within one month of admission to the designated centre.

**Please state the actions you have taken or are planning to take:**
1. A new contract of care will be designed to include the new name of the registered provider.
2. A meeting planner for all families to meet with management will be drawn up for the month of April.
3. The management will meet with all residents and their families to discuss the new contract and to sign off.
4. Each resident will have a signed copy of the new contract on their file.

**Proposed Timescale:** 30/04/2014

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### Outcome 03: Suitable Person in Charge

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The persons in charge did not consistently demonstrate authority and accountability for the provision of the service.

**Action Required:**
Under Regulation 15 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge is a nurse with a minimum of three years experience in the area of geriatric nursing within the previous six years.

**Please state the actions you have taken or are planning to take:**
The two persons in charge work in a shared role. The roles and responsibilities have been clarified and authority have been informed.

They have both made a commitment to address the problems that arose from the inspection.

1. From the 24th March till the 4th April they will both work full time in the Nursing home to strategically place structures in their management roles, and to define each other’s roles utilising their strength in certain areas.

2. A time management plan will be devised/discussed to help with the shared role and time management

3. A ‘to do’ list to be discussed and will be printed for both Aine & Hazel to structure the 2 weeks (see attached)

**Proposed Timescale:** 30/04/2014

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### Outcome 04: Records and documentation to be kept at a designated centre

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The residents guide did not contain all information as required by the Regulations.

**Action Required:**
Under Regulation 21 (1) you are required to: Produce a residents guide which includes a summary of the statement of purpose; the terms and conditions in respect of
accommodation to be provided for residents; a standard form of contract for the provision of services and facilities to residents; the most recent inspection report; a summary of the complaints procedure provided for in Regulation 39; and the address and telephone number of the Chief Inspector.

Please state the actions you have taken or are planning to take:
1. The residents guide has been in place and available to all residents in their bedrooms
2. The resident’s guide will be up-dated with the details required by the regulations.
3. A copy will also be on display in the conservatory where residents and families may avail

**Proposed Timescale:** 31/03/2014

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Records in relation to residents were not fully completed and contained gaps in information.

Records in relation to residents were not kept in a secure place.

**Action Required:**
Under Regulation 22 (1) (ii) and (iii) you are required to: Keep the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) up-to-date and in good order and in a safe and secure place.

Please state the actions you have taken or are planning to take:
1. Staff have been made aware through staff meeting of the deficit in the documentation of residents records. Staff have made a conscious effort to improve on this deficit.

2. Care assistants have taken the responsibility of documenting activities of daily living, challenging behaviours and daily records.

3. Nurses have been up-dating care plans in a more timely manner. Aine & Hazel are overseeing this is completed.

4. A new daily record sheet has been designed which incorporates fluid balance sheet, Restraint release form, repositioning chart, comments on skin condition, comment on appetite and activities or visitors by the residents. This was designed so that documentation will be consistent.

5. A storage unit for the care plans will be purchased.

**Proposed Timescale:** 31/03/2014
**Theme: Leadership, Governance and Management**

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The directory of residents did not include all information as required by Regulations.

**Action Required:**
Under Regulation 23 (2) you are required to: Ensure that the directory of residents includes the information specified in Schedule 3 paragraph (3) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 as amended.

**Please state the actions you have taken or are planning to take:**
1. The Registration book itself does not hold a space for gender of resident. We have since January 2012 provided additional information in a file ‘residents status’ on the gender of our residents.

2. A copy has been forwarded to the authority.

**Proposed Timescale:** 14/03/2014

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**Theme: Leadership, Governance and Management**

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no insurance cover in place against loss or damage to the property of residents.

**Action Required:**
Under Regulation 26 (2) you are required to: Put insurance cover in place against loss or damage to the property of residents including liability as specified in Regulation 26 (2).

**Please state the actions you have taken or are planning to take:**
1. Insurance is in place to cover for loss or damage to the property of residents.

2. A copy has been forwarded to the authority.

**Proposed Timescale:** 14/03/2014

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**Outcome 06: Safeguarding and Safety**

**Theme: Safe Care and Support**

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure adequate systems were in place to protect residents from all forms of abuse.
Safeguarding measures to protect residents from financial abuse were not robustly followed.

**Action Required:**
Under Regulation 6 (1) (a) you are required to: Put in place all reasonable measures to protect each resident from all forms of abuse.

**Please state the actions you have taken or are planning to take:**
As outlined in outcome 6 in the report, cash was withdrawn from a resident's personal monies without knowledge of the resident. This cash was used to pay for a taxi of another resident.

A centre led investigation was forwarded to the Authority.

1. A finance meeting was held on 7th March with all 3 managers to discuss the actions to be taken

2. The Finance Policy was reviewed and now includes a procedure for handling resident cash on site. This procedure includes management of keys, staff misconduct. This procedure will be rolled out to staff at the next staff meeting

3. A Finance Audit was completed by Patricia Robinson on 8th March, and will be completed every 3 months thereafter. The Finance Audit outlines the risk factors. (attached to report)

4. The resident account sheets have been reviewed to make them transparent in transactions.

5. A petty cash box with a Float of €100 is available to staff should the need arise for any resident in an emergency.

6. Residents Monies will be capped and counted by 2 members of the management team every Friday.

7. Personal possessions will be recorded when on admission with the resident and their families. Current personal possession lists will be reviewed and updated with families.

**Proposed Timescale:** 13/03/2014

**Theme:** Safe Care and Support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Training or other measures was not in place for some staff in the protection of vulnerable adults.
**Action Required:**
Under Regulation 6 (2) (a) you are required to: Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.

**Please state the actions you have taken or are planning to take:**
1. At the time of inspection 11 staff members had not completed in-house elder abuse training.
2. Out of the 11 there is 5 Nurses who work as agency.
3. They have received their training in other centres. We will request their certificates for their staff files.
4. And 1 nurse had been on maternity leave.
5. The 5 remaining staff members in need of Elder abuse training will be met with on the dates between 2-4 April & 16-18 April 2014, in line with their off duty hours.

**Proposed Timescale:** 30/04/2014

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## Outcome 07: 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:
A gap in a double door fire door may pose a risk.

**Action Required:**
Under Regulation 32 (1) (b) you are required to: Provide adequate means of escape in the event of fire.

**Please state the actions you have taken or are planning to take:**
1. The door has been modified to close and make no gap with the in-house maintenance staff.
2. A price has been sought for a new double door, so as to ensure complete compliance.
3. The door will be purchased and installed by the in-house maintenance staff.

**Proposed Timescale:** 31/03/2014

**Theme:** Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all staff had not been provided with up-to-date training in fire safety.
### Action Required:
Under Regulation 32 (1) (d) you are required to: Provide suitable training for staff in fire prevention.

**Please state the actions you have taken or are planning to take:**
1. Staff have been updated on Fire Prevention Training
2. A future training schedule will be written up by Aine & Hazel by 4/4/14

**Proposed Timescale:** 04/04/2014

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### Outcome 10: Reviewing and improving the quality and safety of care

**Theme:** Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The system of audit of quality and safety issues was not effective to improve the service.

**Action Required:**
Under Regulation 35 (1) (b) you are required to: Establish and maintain a system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.

**Please state the actions you have taken or are planning to take:**
1. The persons in charge and the provider will establish and maintain a system of auditing that ensure best practise and continued learning outcomes.
2. The Audit Areas & dates have been reviewed and confirmed and will continue to be a focus at management meetings
3. Since the inspection the Risk management audit review has been completed.
4. A medication management audit has been created and will be actioned by Aine & Hazel on the weeks of 24/3/14---4/4/14.
5. We have commenced on food and nutrition, end of life care, wound care, infection control. This will be actioned over the next 2 weeks with both persons in charge.

**Proposed Timescale:** 31/05/2014

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### Outcome 11: Health and Social Care Needs

**Theme:** Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The management of falls required improvements for example, after a resident fell the
additional interventions to prevent future falls were not outlined in their care plan.

The management of behaviours that challenge required improvement. For example, there were gaps in monitoring charts reviewed and care plans did not guide the care to be delivered.

**Action Required:**
Under Regulation 6 (3) (a) you are required to: Put in place suitable and sufficient care to maintain each residents welfare and wellbeing, having regard to the nature and extent of each residents dependency and needs.

**Please state the actions you have taken or are planning to take:**
1. Staff have been made aware, through staff meeting and daily reports, of the deficit in the documentation of residents records. Staff have made a conscious effort to improve on this deficit.

2. Care plans will be updated to outline the learning outcomes and interventions considered for each resident following a fall by the nurse allocated to the resident care plan.

3. The accident forms have been revised to include a question for staff on filling out the falls diary & care plans interventions.

4. Interventions and learning outcomes outlined in the management falls bi-weekly audit, will be made known to the nurse for the care plan.

5. Care assistants have been given the responsibility of documenting challenging behaviours as they happen as they are in closer contact with the residents on a personal hygiene and activity level.

6. The persons in charge and the provider have developed guidelines for the staff to follow in relation to residents that present with behaviours that challenge. These guidelines and interventions will be written into individuals care plans.

7. All staff have up to date training on responding to behaviours that challenge.

**Proposed Timescale:** 31/03/2014

**Theme:** Effective Care and Support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no formal review of residents’ care plans in relation to their identified needs.

**Action Required:**
Under Regulation 8 (2) (b) you are required to: Keep each residents care plan under formal review as required by the residents changing needs or circumstances and no less frequent than at 3-monthly intervals.
Please state the actions you have taken or are planning to take:
1. Each Nurse has been assigned 4/5 residents care plans on which to document and update. This Nurse is responsible for the formal review of the care plans assigned to them. The person in charge will oversee the formal review dates to ensure that all formal reviews happen within the correct timeframe of 3 monthly intervals.

2. We will enhance this by providing a time frame for the Nurses to have the formal review complete. The PIC will then review each care plan every 3 months to ensure the formal reviews are performed correctly.

Proposed Timescale: 31/03/2014
Theme: Effective Care and Support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was inconsistent evidence of consultation with residents of their care plan.

Action Required:
Under Regulation 8 (2) (c) you are required to: Revise each residents care plan, after consultation with him/her.

Please state the actions you have taken or are planning to take:
1. The PIC’s have started documenting all conversations had with Residents and or their significant others in relation to all aspects of care. Dates and times and topics covered are documented.

2. We will have 3 monthly meetings with all residents and or significant others to formalise the consultation of their care and care plans.

3. Next meetings will be held in April 2014 –diary dates to be confirmed in the next week

Proposed Timescale: 30/04/2014
Theme: Effective Care and Support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plans were not consistently individualised to meet each residents needs.

Action Required:
Under Regulation 8 (1) you are required to: Set out each resident’s needs in an individual care plan developed and agreed with the resident.

Please state the actions you have taken or are planning to take:
1. The office computer will be available for nurses to type up resident specific individual care plans.
2. Templates will be available to guide nurses in the process of care planning.

3. This template will ensure the care plan is person centred and individualised.

4. Aine & hazel will discuss this with each Nurse over the coming weeks when they overview all care plans

**Proposed Timescale:** 31/05/2014

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**Outcome 12: Safe and Suitable Premises**

**Theme:** Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The centre was in need of refurbishment and repair works in areas.

The three three bedded rooms will not fully meet the needs of residents', and meet the criteria of the National Standards by 2015.

The details of a definite, costed plan with specific times shall be included in the response.

**Action Required:**

Under Regulation 19 (3) (a) you are required to: Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.

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

1. The finish to the wall of the staff facilities has been completed, and is compliant with the regulations.

2. The laundry floor has been covered with R11 vinyl, which is slip rated floor covering

3. A meeting was held with the architect on Tuesday 12th March 2014. He has been unavailable to us since before December 2013.

4. The Architect has made a commitment to have the planning permission application lodged by 28th March 2014.

5. The architect is to organise a meeting with the council prior to submitting the plans for planning permission, to avoid any unnecessary delays in approval.

6. The plans will then be costed. When this has been achieved, we will submit specific times to the authority.

**Proposed Timescale:** 30/06/2015
Theme: Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was inadequate storage for equipment.

The details of a definite, costed plan with specific times shall be included in the response.

Action Required:
Under Regulation 19 (3) (l) you are required to: Ensure suitable provision for storage of equipment in the designated centre

Please state the actions you have taken or are planning to take:
1. There has been additional storage added to the plans of the new build.
2. Costings will be discussed with the Architect.

Proposed Timescale: 30/06/2015

Theme: Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was inadequate mechanical light in parts of the centre.

The details of a definite, costed plan with specific times shall be included in the response.

Action Required:
Under Regulation 19 (3) (p) you are required to: Provide ventilation, heating and lighting suitable for residents in all parts of the designated centre which are used by residents.

Please state the actions you have taken or are planning to take:
1. The lighting in darkened areas was reviewed by management & maintenance. It was established that the main problem was investigated as
   • Lampshades unsuitable for maximum omission of light
   • Lamp shades are creating down lighting
   • Light bulbs were glazed/frosted
   • Long life light bulbs delay in lighting to the maximum

2. Management & maintenance have reviewed the different aspects of lighting & light. Maintenance staff is researching the best lighting options.

3. The most appropriate lighting for the centre will be costed and inserted in the centre.

Proposed Timescale: 31/03/2014
**Theme:** Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was inadequate dining space for all residents at mealtimes.

The details of a definite, costed plan with specific times shall be included in the response.

**Action Required:**
Under Regulation 19 (3) (g) part 1 you are required to: Provide adequate sitting, recreational and dining space separate to the residents private accommodation.

**Please state the actions you have taken or are planning to take:**
1. As reported in previous action plans, there are 2 sittings at each meal time to accommodate all the residents.
2. A new larger dining room is included in the plans of the new build.
3. The new dining room will accommodate 21 residents at meal times.

**Proposed Timescale:** 30/06/2015

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**Outcome 13: Complaints procedures**

**Theme:** Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The overall response and investigation of complaints requires improvement.

**Action Required:**
Under Regulation 39 (6) you are required to: Investigate all complaints promptly.

**Please state the actions you have taken or are planning to take:**
1. Following a management meeting, the complaints form has been reviewed and updated to include the
   - Investigation of the complaints officer
   - Action taken
   - Complaint type verbal /written
   - Complaints officer signature
   - Action plan needed
   - Follow up needed
2. Additional signs will be placed in certain area’s in the home to indicate how to make a complaint.
3. Letters have been written up, with a number of information details for families, and will be sent out to families by 31 March 2014.
• Complaints procedure
• Weekly Menu
• Activities
• Care plans meetings

4. Each week the complaints officer will review all complaints made.

5. Each month complaints will be audited by all 3 managers at management meeting.

**Proposed Timescale:** 31/03/2014

**Theme:** Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policies and procedures on the management of complaints were not fully implemented in practice.

**Action Required:**
Under Regulation 39 (1) you are required to: Provide written operational policies and procedures relating to the making, handling and investigation of complaints from any person about any aspects of service, care and treatment provided in, or on behalf of a designated centre.

Please state the actions you have taken or are planning to take:
1. The previous provider's name shall be removed from the old policy and re-printed

2. Verbal complaints shall be resolved at the time of the complaint.

3. The complaints officer will review each complaint weekly and sign off.

**Proposed Timescale:** 31/03/2014

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**Outcome 18: Suitable Staffing**

**Theme:** Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The contingency measures in place to cover staff on leave in the event of an emergency were not adequate.

**Action Required:**
Under Regulation 16 (1) you are required to: Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.
Please state the actions you have taken or are planning to take:
In keeping with the ethos of the Nursing Home, and considering its size and resident numbers, the management have discussed the use of agency staff at management meeting.

If we were to depend on an agency night & weekend cover in emergency, it is probable that Aine/Hazel would accompany the agency staff for the most part of the shift to complete an induction. This brings up issues of Aine/Hazel being present and supporting the agency staff during the night/weekend. Induction includes,

- Induction of building
- Introduce residents
- Induction of medication rounds
- Induction of the fire safety procedures
- Discuss elder abuse/challenging behaviours
- Induct on diets & care plans
- Health & safety procedures

In the event that a staff nurse phones in sick or unable to come to work;

- A panel of Nurses is written up for off duty sick cover
- The 5 Nurses who work full time are contacted to consider if they are available for work
- The 6 Nurses who work as relief are contacted to consider them available for work
- In the event that none of the panel are available, the management will contact the agency.
- Management will contact agency firms to leave details etc.
- We have hired a new male Nurse in February 2014. We have had no staff shortages since February 2014.
- The PIC covered 2 night shifts prior to the inspection, as the night nurse phoned in sick at 4pm one evening and our permanent night Nurse was on annual leave. Following a phoning of the panel, no nurses from the relief panel were available for cover on those nights.

**Proposed Timescale:** 31/03/2014

**Theme:** Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A number of staff had not been provided with up-to-date mandatory training.

**Action Required:**
Under Regulation 17 (1) you are required to: Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence based practice.
Please state the actions you have taken or are planning to take:
1. Mandatory training for staff will be reviewed and a timetable will be implemented for the coming year.

Proposed Timescale: 31/03/2014

Theme: Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no formal system in place for the supervision of staff.

Action Required:
Under Regulation 17 (2) you are required to: Supervise all staff members on an appropriate basis pertinent to their role.

Please state the actions you have taken or are planning to take:
1. There is documented staff meetings every 6-8 weeks
2. Concerns are raised & addressed at these meetings.
3. Minutes of these meetings are circulated and read by staff members
4. Both PIC’s are at handover meetings at 8am every morning.
5. PIC’s link in with staff daily in regards to, resident welfare, reporting, daily duties/routines, break times, tardiness etc.
6. Going forward the PIC will document the supervision that was given to each staff, through monthly documented reviews
7. Performance reviews will commence May 2014 and a dated plan will be rolled out to all staff over the coming month to inform them of individualised performance and development reviews.

Proposed Timescale: 31/05/2014