<table>
<thead>
<tr>
<th>Centre name:</th>
<th>The Tower Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-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>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Clondalkin Nursing Home Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Patricia Robinson</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Noelene Dowling</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>19</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>2</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 judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

The inspection took place over the following dates and times

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
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<tbody>
<tr>
<td>03 February 2015 10:30</td>
<td>03 February 2015 20:00</td>
</tr>
<tr>
<td>04 February 2015 08:00</td>
<td>04 February 2015 15:30</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome 01: Statement of Purpose</th>
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<tr>
<td>Outcome 02: Governance and Management</td>
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<tr>
<td>Outcome 03: Information for residents</td>
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<td>Outcome 04: Suitable Person in Charge</td>
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<td>Outcome 05: Documentation to be kept at a designated centre</td>
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<td>Outcome 06: Absence of the Person in charge</td>
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<td>Outcome 07: Safeguarding and Safety</td>
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<td>Outcome 08: Health and Safety and Risk Management</td>
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<td>Outcome 09: Medication Management</td>
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<td>Outcome 10: Notification of Incidents</td>
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<td>Outcome 11: Health and Social Care Needs</td>
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<td>Outcome 12: Safe and Suitable Premises</td>
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<td>Outcome 13: Complaints procedures</td>
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<td>Outcome 14: End of Life Care</td>
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<td>Outcome 15: Food and Nutrition</td>
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<td>Outcome 16: Residents' Rights, Dignity and Consultation</td>
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<td>Outcome 17: Residents' clothing and personal property and possessions</td>
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<tr>
<td>Outcome 18: Suitable Staffing</td>
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Summary of findings from this inspection

This was the 9th inspection of this centre and took place over two days. The purpose of the inspection was to inform the decision of the Authority in relation to the application by the provider to renew the registration of the centre which was granted registration in 2012. All documentation required for the registration process was provided.

The inspector also reviewed the actions outstanding following the previous inspection which took place in January 2014 and found that the provider had made significant progress in addressing the non compliances identified by the inspection and demonstrated a commitment to improvement. Of the 22 actions required nine had been satisfactorily completed and actions had been taken in relation to ten other non

Page 3 of 30
compliances identified. The specific actions not addressed related to the deficits in the premises in order to provide suitable communal and sleeping accommodation. The provider stated that planning permission for an extension and renovation was in process and funding had been sought in order to remedy this. The inspector reviewed questionnaires from residents. The commentary was very positive and included that the staff are like my friends, I can tell them anything and the staff and managers are very kind. The inspector noted that staff knew the residents very well and care was delivered at the residents pace with good communication and respect for individual residents evident.

Areas of non compliance were found in:
• the management of residents’ health care needs and care plan documentation.
• fire safety systems
• the protection of vulnerable adults in terms of staff reporting poor practice.
• consistent staffing to ensure care was delivered as required
• evidence of mandatory training for external staff
• recruitment procedures
• training for staff in supporting residents with cognitive behaviour and monitoring of staff in managing behaviours
• use of methods of restraint
• suitable premises.
The actions required to achieve compliance with the Health Act (Care and Welfare of Residents in Designated Centres for Older People) Regulations (as amended) are outlined at the end of this report.

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

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

Theme:
Governance, Leadership and Management

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

Findings:
The statement of purpose had been forwarded to the Authority as part of the application for registration. It was found to be in compliance with the regulatory requirements. Admissions to the centre and care practices implemented were congruent with the
Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
Governance systems had been reviewed and implemented following the previous inspection and overall the inspector was satisfied that systems were satisfactory. A number of systems were used including audits, regular management and staff meetings and monitoring of practices to support the governance. Clinical and environmental audits took place. These included incidents, falls, wounds, medication administration and/or errors. The collated information was reviewed and trends identified. The system for review of the service included the views of the residents. An annual report has not as yet been compiled but the systems in place and the data collated will provide sufficient information for the provider to undertake this.

Judgment:
Substantially Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
There was a resident’s guide available and each resident is provided with a contract for
care which was signed within one month of admission. All fees were detailed and outlined in the contract. Additional costs were minimal and these were clearly outlined in the contract.

**Judgment:**
Substantially Compliant

### Outcome 04: Suitable Person in Charge

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
Satisfactory actions had been taken by the provider to address the issues identified by the previous inspection. A clearly defined management structure there was a clearly defined management structure which identified the lines of authority and accountability in the centre and reporting mechanisms.

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 one day they work together. They also share on call at weekends and the inspector saw detailed handover documentation to ensure consistency between both persons. 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 to facilitate the process. Clear job descriptions outlining various roles had been devised. Reporting systems with the provider were in place at a formal and informal level.

**Judgment:**
Substantially Compliant
### Outcome 05: Documentation to be kept at a designated centre

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

<table>
<thead>
<tr>
<th>Theme:</th>
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</thead>
<tbody>
<tr>
<td>Governance, Leadership and Management</td>
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<table>
<thead>
<tr>
<th>Outstanding requirement(s) from previous inspection(s):</th>
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</thead>
<tbody>
<tr>
<td>No actions were required from the previous inspection.</td>
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<thead>
<tr>
<th>Findings:</th>
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<tbody>
<tr>
<td>The inspector found that the records required by regulation in relation to residents, including medical records and nursing records were up to date, easily retrieved with some minor improvements required. However, while all residents had up to date assessments and care plans, some were not dated and some were not reflective of the changes which had taken place in the resident’s health or mobility. This is actioned under Outcome 11 Health and Social Care Needs. The documentation required by Schedule 2 in respect of staff members was not consistently available.</td>
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All of the required policies were in place and had been revised. Documents such as the residents guide and directory of residents were also available and had been amended following the previous inspection. The inspector saw that insurance was current and included the liability for resident’s personal property. Reports of other statutory bodies were also available. Written evidence of compliance with the statutory fire authority had been forwarded to the Chief Inspector as part of the application for registration. A visitors log was available.

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
There were satisfactory arrangements in place for the absence of the person in charge. The inspector was satisfied that each of the post holders undertake the duties and rota of the other in any such periods of leave or absence.

**Judgment:**
Compliant

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

**Theme:**
Safe care and support

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

**Findings:**
While the inspector was satisfied that safeguarding procedures were in place there were areas for improvement required in ensuring that these were implemented by all staff.

The action required from the previous inspection regarding the management of monies held on resident’s behalf had been resolved and stringent systems were implemented to prevent any re-occurrences. A review of a sample of records of fee payments and transactions for residents including a number of residents for whom the provider acts as agent found that the records were transparent. The required documentation was in place and residents could at any time be given a detailed statement of their finances including fee payments. The provider also instigated appropriate procedures with external agencies where there were any concerns regarding residents finances involving
The inspector reviewed the policy and procedure on the prevention, detection and reporting of abuse and found that it was satisfactory and in line with all guidelines. Some improvements were required in safeguarding measures however. Records demonstrated that all staff had received updated training in the prevention, detection and response to abuse but there was no evidence that some of the external staff who provided consistent relief cover had undertaken this training. Staff spoken with demonstrated an understanding of their own responsibilities in relation to the protection of residents and signs and symptoms of abuse which would indicate concern.

The inspector reviewed the records of a concern which was raised by a resident. The provider and the person in charge acted responsibly and took appropriate actions in relation to this. However, the inspector was concerned that staff on duty at the time had not in this instance acted to report the concern on behalf of the resident or intervened as it occurred. The provider had not addressed this aspect of the issue when managing the concern.

Residents informed the inspector that they felt safe and well cared for in the centre. They were familiar with the provider and person in charge and expressed their confidence in being able to address any issues.

A significant number of the residents had a diagnosis of dementia and or enduring mental health issue and some presented with challenging behaviours. There was a policy on the management of challenging behaviours which was in accordance with national policy and guidelines and outlined the need to identify the underlying causes of behaviours and provide proportionate and adequate responses.

In practise staff were able to articulate an understanding of the resident’s behaviours. They were observed to be tolerant and calm and in the main very kind in supporting these residents. A number of care plans were implemented in terms of the most supportive strategies to use however they were not consistently implemented by staff in the management of the residents behaviours. This is auctioned under Outcome 18 Workforce.

A review of Pro-re-nata (as required) medication demonstrated that medication was not used in any excessive way to manage behaviours and staff noted if residents were overly sedated. There was evidence of multidisciplinary review from psychiatry of old age where this was required. The action in relation to the assessment for the use of methods of restraint and the implementation of alternatives required at the previous inspection had not been entirely addressed. The assessment tool did not sufficiently outline the alternatives which had been tried in some instances or the outcome of the trial. There was not sufficient attention paid to the resident’s agitation or likelihood to attempt to exit the bed and be placed at further risk. In practice a number of low beds were used and in some instances bed rails were not used. There was evidence that residents were checked regularly when using the bed rails.
Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
Issues identified at the previous inspection in relation to risk had been addressed. These included the suitability of the hand rails, suitable lighting in specific areas of the centre and flooring in the laundry and sluice facility. An unsuitable fire door had also been replaced. There was a current and signed health and safety statement available. Systems for review of safety and risk were evident. The risk management policy was in compliance with the regulations including the process for learning from and review of untoward events. The policy was supported by relevant policies including an emergency plan.

The emergency plan contained all of the required information including arrangements for the interim accommodation of residents should this be required. A health and safety committee met every few months and reviewed safety measures. There was also a maintenance person available who undertook routine safety checks of the premises.

Emergency phone numbers were available to staff. Core safety features including flooring, hand-rails, working call-bells and secure exits and entrances were evident. Training records demonstrated that fulltime staff had undergone training in moving and transporting residents. However, while the provider stated that the panel of relief staff had done this in other centres there was no documentary evidence of this.

The risk register contained details of environmental risks and appropriate actions taken to mediate them. However, it did not include clinical risk of relevance to the residents such as the risk of developing pressure sores or medication errors which would support risk management practice in these areas. The provider agreed to review this.

Policy on the prevention and control of infection was satisfactory and staff were knowledgeable on the procedures to be used on a daily basis and in the event of any specific infection related concern.

Fire safety management systems were in place but a number of improvements were required. There was only one ski sheet available in the premises. Given the dependency levels of some of the residents on the first floor, others may be required in the event.
that they were necessary. The exit doors were locked by key and at night not all staff carried the keys to the doors which could place residents at risk as the keys were not secured at the exits. There was no evacuation plan available for the residents detailing their individual mobility needs in the event that this was required. All staff including the external staff had undergone fire safety training annually and drills were held twice yearly. The fire procedure was displayed and staff spoken with appeared to be knowledgeable on the procedures to be used in such an event. Smoking assessments had been undertaken on the residents who smoked and suitable safeguarding arrangements were in place.

Documentation confirmed that the fire alarm and emergency lighting was serviced quarterly and other equipment serviced annually as required. Daily checks on the exit doors and the fire panel were recorded. Fire doors were in place.

**Judgment:**
Non Compliant - Moderate

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**Outcome 09: Medication Management**

*Each resident is protected by the designated centre’s policies and procedures for medication management.*

**Theme:**
Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

The inspector had some concerns that staffing impacted on the safe administration of medication. Twenty one errors or near misses had been reported since 2013 and inspectors found that these had been reviewed promptly and appropriate actions taken to prevent re-occurrences. There were no significant ill effects to the residents reported. However, the type of error or near miss suggests this may be related to the use of numerous different nursing staff at night that are not sufficiently familiar with the resident’s medication or changes to the medication despite the handover systems in place.

Current policy on the management of medication was centre-specific and in line with legislation and guidelines. Systems for the receipt of, management, administration, storage and accounting for controlled drugs were satisfactory. There were appropriate documented procedures for the handling, disposal of and return of medication. There was evidence on records that medication was reviewed three monthly or more often for individual residents where this was deemed necessary. Nursing staff had received training in medication management in 2014.

Records demonstrated that staff observed residents response to medication and reported to the resident’s general practitioner (GP) or relevant clinician and amendments
were made where these were necessary. An audit of medication usage and identification of psychotropic medication had been undertaken by the pharmacist. At the time of this inspection, no residents were deemed to have the capacity to self-administer medication.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Safe care and support

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

**Findings:**
A review of notifications and accident and incident records maintained in the centre indicated that the provider was in compliance with the obligation to notify the Authority as required by the Chief Inspector.

**Judgment:**
Compliant

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**Outcome 11: Health and Social Care Needs**
*Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.*

**Theme:**
Effective care and support

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

**Findings:**
A number of the actions required from the previous inspection had been satisfactorily resolved but some improvements were still required to ensure the satisfactory delivery of care. These were primarily in relation to the completion of documentation, accurate
assessment and prompt access to treatment when required.

A number of GPs provide health care to the residents and many have retained the services of their own GP. The inspector was not satisfied that in instances where a resident was clearly symptomatic of infection and had a nursing diagnoses of this that prompt access to GP review and treatment was sought in a timely fashion. There was a delay of 5 days between noting of symptoms and access to appropriate medical review in one instance. There was also a delay of twenty four hours in following the instruction left by a nurse in relation to this.

Records demonstrated that residents had access to allied services including speech and language, physiotherapy, occupational therapy, psychiatry of old age, chiropody, opthalmatic and dentistry. The recommendations made by the specialists were detailed in the residents’ records and staff were knowledgeable on these recommendations.

While the admission process required an assessment by the person in charge, the inspector found that the information was not detailed enough to enable an informed decision to be made. Although care plans were devised promptly following admission, the records showed that residents were not consistently seen by GPs in some instances for up to 8 days following admission.

There was evidence that the care plans were fully reviewed four monthly and the overall quality of the information had improved. Falls assessments were undertaken and care plans were reviewed following any incident. However, some care plans did not accurately reflect the president’s health care or psychosocial needs. For example, the management of epilepsy or diagnosed mental health issues which impacted on the delivery of care. There was contradictory information noted in the manual handling plan and the care plan for another resident’s mobility needs. In some instances the information was not accurate. An assessment of skin integrity did not accurately reflect the status of the resident. Some wound care documentation demonstrated gaps in adherence to the treatment plans although the treatment plan itself was detailed. Advice from tissue viability specialists was evident. The inspector acknowledges that wounds were not a significant feature in the centre and that the condition was healing.

Resident weights and food and fluid intake were monitored in accordance with the resident’s condition and under the direction of the dietician who had also reviewed the menus available. There was evidence of regular consultation with residents and relatives in regard to the care plans.

**Judgment:**
Non Compliant - Moderate
### Outcome 12: Safe and Suitable Premises

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

**Theme:**

Effective care and support

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

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

**Findings:**

The premises were warm, and had a homely environment but improvements are required to ensure it meets the needs of the residents. Actions identified at the last inspection including poor lighting had been resolved. The premises in general were in a poor state of repair and in need of refurbishment including painting and replacement of carpets and other flooring.

The premises are comprised of a combined dining and day room. The dining area is not large enough to accommodate the number of residents and had seating for twelve residents. Two sittings were held for meals and some residents had their meal on a tray. There is a small conservatory to the side of the day room which can be used for visitors and the nurses’ station is also located here.

Bedroom accommodations on the ground floor consists of one double bedroom, seven single bedrooms and two three bedded rooms. There are two assisted showers and toilets on the floor in close proximity to the bedrooms. The first floor consists of three double bedrooms and six single bedrooms. All have suitable lockers and wardrobes. There is an assisted shower room and toilet on this floor and an assisted bathroom with adapted bath. The three bedded rooms are of satisfactory size to allow for personal furniture and the use of assistive equipment to be used with suitable screening and room to maintain privacy and dignity while doing so.

Three of the double bedrooms are not of a satisfactory size to accommodate the residents, provide adequate personal space and ensure that assistive equipment can be used and that their privacy and dignity can be maintained while doing so. They do not meet the minimum space requirements. This was observed by the inspector and the provider concurred with this.

There is a laundry and staff facility in the garden which is easily accessed and suitable for the residents use. The kitchen is suitably equipped and there are suitable sluice facilities. Storage for equipment is problematic which results in wheelchairs and hoists left in bedrooms. There are two internal stars and a chairlift which had been regularly serviced.
The person in charge advised the inspector that there is a definitive plan in place to address the deficits in the premises which was awaiting approval and funding.

**Judgment:**
Non Compliant - Moderate

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

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

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

**Findings:**
The action from the previous inspection regarding the role of the designated officer, the documenting of all complaints and function of the person nominated to oversee the process had been resolved. There were written operational policies and procedures for the making and management of complaints. There was also an external person appointed to act as an independent appeals person for residents should they require this. The process of local resolution of complaints was undertaken by the person in charge and the provider.

The sample of complaints viewed by the inspector indicated a willingness to address issues raised. Where issues could not be clarified the provider acted responsibly and replaced items or monies which were alleged to have been mislaid and reverted to the complainant in regard to this. Adequate records were maintained. Residents and relatives spoken with indicated that they were aware of how to make a complaint and felt confident in doing so.

**Judgment:**
Compliant

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

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

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

Findings:
Overall the inspector was satisfied that there was a commitment to supporting residents medical and psychosocial needs at this stage of life with some improvements required. There was a written operational policy on end of life care which demonstrated that issues such as advanced planning and ascertaining the resident’s wishes was paramount. However, records reviewed indicated that there was very little opportunity taken at an early stage to ascertain the residents or the relative’s wishes in regard to treatment options, admission to acute services or resuscitation. The provider agreed to review this in consultation with the residents.

The care planning documentation contained practical information such as the resident’s religious persuasion, next of kin and interment arrangements. Staff explained that they usually wait until a resident becomes ill to discuss end of life with the family. In some instances it was apparent from records that residents did not wish to discuss this matter and this was respected. Palliative care services were available should these be required and the inspector was informed that these had been used successfully in the past.

Judgment:
Substantially Compliant

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

Theme:
Person-centred care and support

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

Findings:
Relevant policies and guidelines were in place to support nutritional intake and hydration. There was evidence on records available of the consistent monitoring of residents nutritional status and needs. The malnutrition universal screening tool (MUST) was undertaken and repeated to identify any residents at risk. Weights are monitored either weekly or monthly as dictated by the residents needs. There was evidence of referral to dieticians and speech and language therapists for all those residents on either modified or altered consistency diets. There was a documentary system for communicating specific dietary requirements between the catering and nursing staff. Staff were found to be knowledgeable on these dietary requirements and the correct fluid consistencies prescribed for residents and these were observed.

Residents, including those on modified foods were offered a choice at all meals and the
menu was seen to be varied. Meals observed including modified meals, were presented in an appropriate and appetising manner. Snacks and hot and cold drinks including juices and fresh drinking water and soup were readily available throughout the day. Food was available for late evenings and those residents on puréed diets were provided with foods such as rice and custards. Other foods were available for snacks at different times of the day including fresh fruit twice daily. All residents spoken with complimented the food.

A food safety management plan was in place. The provider informed the inspector that no actions were identified from the most recent environmental health report. Catering staff had completed the required food safety training. Residents were provided with additional supplements as deemed necessary and prescribed by the medical officer.

The inspector observed that there was sufficient staff to ensure residents were supported in an unhurried manner with staff observed to be communicating and encouraging those residents who need this.

**Judgment:**
Compliant

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

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

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

**Findings:**
The action required in relation to the safe and confidential management of residents files had been satisfactory completed with a secure filling cabinet being used at the nurses’ station and the activities available for residents. Residents who could communicate with the inspector were able to articulate their medical and care needs and indicated that they were consulted in regard to their care. It was apparent that there was choice in regard to their daily routines such as getting up, attending activities and when they took their meals.

The inspector found evidence of consultation with residents. Minutes from residents meetings were seen which were held to ascertain resident’s feedback in relation to the running of the centre and their experience of care. These took place regularly and records showed a good attendance by the residents. The inspector confirmed that issues
which were raised including food choices or activities were addressed by the provider. The feedback from these meetings was supplemented by an annual feedback questionnaire circulated by the Person in Charge and the collated outcome was overall very satisfactory with action taken by the provider in response to any issues raised.

Newspapers and other media such as television were evident. Currently residents who wish to vote were brought by staff to the local polling station. The provider agreed to make arrangements for in-house polling in the future so that all residents can participate. There was also an open door visiting policy which was seen in practice throughout the two days of the inspection.

Since the last inspection the provider had assigned two dedicated activities staff who work opposite each other. Resident were provided with questionnaires to ascertain their preferences and personal interest. The activities include bingo, reading the newspapers, age appropriate DVDs, quizzes, walks for individual residents, music twice weekly and for some residents hand massage art and listening to preferred music and art. Small group activities were organised such as trips to local amenities. One resident goes out alone each day to places of personal interest and looks after his own affairs supported by the staff. The activities staff were provided with training including Activities in Care and SONAS (a therapeutic intervention). Sonas is not used as the accommodation doesn’t allow for the group to be divided. The communal accommodation is small and confined and this does impact on the activities available and the ability of residents to have quite time alone.

Residents informed the inspector that their religious needs were met. Mass took place fortnightly and the rosary took place daily for those who wished to participate.

A significant number of residents had cognitive impairment and communication difficulties and in some instances sight or hearing problems. The care plans did not contain guidance on the residents communication needs. There were no systems such as pictorial images or appropriate signage, rummage boxes or other suitable interventions directed at meeting the specific needs of these residents. Overall, the inspector observed staff being respectful and communicating gently and very kindly with the residents. However, the communication style and actions of staff did not consistently demonstrate good practice when dealing with challenging behaviours.

**Judgment:**
Non Compliant - Moderate
### Outcome 17: Residents' clothing and personal property and possessions

Adequate space is provided for residents’ personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

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

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

**Findings:**
There was a policy on the management of residents clothing and possessions. However, the records maintained only detailed the possessions of the residents on admission and therefore were not sufficient to ensure they could retain control over their possessions. Following discussion with the person in charge agreed to review this. Valuables held for safe keeping were recorded and the signature of staff and residents where this was possible was evident. Residents clothing was laundered on the premises and there was no evidence that clothing was not returned to the residents. There was sufficient space to store possessions and clothing.

**Judgment:**
Substantially Compliant

### Outcome 18: Suitable Staffing

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

**Theme:**
Workforce

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

**Findings:**
The action required form the previous inspection had been resolved. The inspector found that the person in charge was not consistently undertaking night duty in
emergencies. The inspector reviewed the actual and planned staff roster and from observation was satisfied that there was a sufficient number and suitable skill mix of staff on duty at all times to meet the needs of residents. In total there was three fulltime nursing staff available aside from the post of person in charge. Up to five separate nurses undertake a variety of part time hours at night. All were employed in other agencies.

While the quota of staff was satisfactory during the day the inspector found that in a week up to five separate night staff were used. The finding of this inspection in relation to the accuracy and implementation of care plans, medication near misses or errors, and follow up on directions left by nursing staff indicates that the deployment of staff at night does not support consistency of care.

As stated in Outcome 8 fire safety training had been provided but there was no evidence available that mandatory training in manual handling and elder abuse had taken place for the staff employed elsewhere. Records of training in manual handling were forwarded following the inspection having been sourced by the person in charge from the staff involved.

Recruitment processes were not in line with the requirements of the regulations. Although a Garda Síochána vetting had been applied for, last employer references were not consistently requested and there was no evidence that information given was verified. A number of references were also procured after the employment had commenced.

There was evidence that staff had been provided with training including training in behaviours that challenged and food and nutrition. A number of health care assistant also had Further Education and Training Awards Council Training (FETAC) level 5 training. However, the findings in Outcome 16 indicate that further training pertinent to the needs of the residents in relation to cognitive impairment and dementia challenging behaviour is required.

An Bord Altranais agus Cnáimhseachais na hÉireann registration numbers for all nursing staff were in place. A supervision appraisal system had been introduced by the provider and an induction program was also implemented for new staff. There was not a high turnover of staff. Staff spoken with during the day were knowledgeable in relation to the residents needs, their own roles, visible and available to the residents.

**Judgment:**
Non Compliant - Moderate
Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>The Tower Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000110</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>03/02/2015 and 04/02/2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>06/03/2015</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 the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

Outcome 05: Documentation to be kept at a designated centre

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Staff files did not contain the required documentation.

**Action Required:**
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
1. The required documentation, which was not on file at time of inspection, is now on all staff files
2. Staff files will be reviewed yearly, as part of non-clinical audit.
3. A new Induction file has been created to include all documentation needed for the staff file, so as to have all documentation to hand for new staff
4. A checklist of all the required documentation will be included on staff files and reviewed at audit
5. The staff file checklist will include
   • Interview notes
   • Reference checks
   • Mandatory Training

Proposed Timescale: 31/03/2015

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge did not ensure that practice in the use of restraint was in accordance with national policy.

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

Please state the actions you have taken or are planning to take:
1. Restraint practises will be reviewed by management at clinical governance meeting
2. The restraint assessment tool will be reviewed to ensure it sufficiently outlines the alternatives which had been tried in some instances or the outcome of the trial.
3. The assessment tool will be reviewed to direct staff to examine the resident’s agitation or likelihood to attempt to exit the bed and be placed at further risk.

Proposed Timescale: 31/03/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff did not have satisfactory training in responding to abuse.

Action Required:
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection
and prevention of and responses to abuse.

Please state the actions you have taken or are planning to take:
1. ‘Detection and prevention of and responses to abuse’ training has been planned for 19th/20th March 2015 for a number of staff in accordance with the staff training plans 2015
2. 5 relief Staff who did not have evidence of training at the time of inspection, have all certificates in place on staff files

Proposed Timescale: 31/03/2015

Theme:
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure that adequate systems were implemented to protect residents from all forms of abuse by ensuring that all staff were trained and that staff adhered to their reporting responsibilities.

Action Required:
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

Please state the actions you have taken or are planning to take:
1. Clinical governance management meeting will include discussion on safe care and support.
2. The ‘Detection and prevention of and responses to abuse’ training will be ammended to further reinforce to staff their reporting responsibilities.
3. Further staff 1-1 discussion will be provided for all staff to outline the reporting responsibilities
4. Ongoing memos and articles will be produced for staff to read, to keep updated on best practise

Proposed Timescale: 31/03/2015

Outcome 08: Health and Safety and Risk Management

Theme:
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some risks to residents including the incidents of pressure areas and medication errors had not been identified.

Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout
Please state the actions you have taken or are planning to take:

1. Audits on both pressure sores and medication errors have been in place since 2012
2. The risk register will be amended to include clinical risk ie. risks to residents, which will identify the incidents of pressure areas and medication errors
3. The risk management audit form will be amended to include these risks

**Proposed Timescale:** 30/03/2015

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Arrangements for the evacuation of residents on the first floor and accessing exit doors were not satisfactory

**Action Required:**
Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

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

1. 12 ski-sheets have been ordered from S&E care trade to be delivered March 2015
2. S&E will provide training when ski-sheets are delivered
3. All staff day/night will be issued with a key for the main front exit doors
4. A key procedure will be written up for staff on duty
5. An evacuation plan will be written for residents detailing their individual mobility needs in the event of an emergency
6. This evacuation plan will be included on all fire management documentation
7. This evacuation plan will be included on all fire training for staff
8. A fire monitoring system has been installed following the inspection (24th Feb) This monitor allows staff to locate fire in specific room
9. This new system is linked up to monitoring service by TOP security in the case of fire/emergency
10. The Fire Management policy will be updated to include the new monitoring system
11. A record Fire drills will take place to ensure all staff are familiar with the new system
12. Following the inspection, 75% of staff have been trained in the use of Fire extinguisher/blanket

**Proposed Timescale:** 30/04/2015

**Outcome 09: Medication Management**

**Theme:**
Safe care and support
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Systems for the safe administration of medication were not satisfactory.

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

Please state the actions you have taken or are planning to take:
1. Although the inspector had some concerns that staffing impacted on the safe administration of medication, on re-evaluation of the errors, it is evident that medication errors occurred mainly due to errors of a new member of the nursing staff.
2. PIC’s are assured that the part time nursing staff are up to date on knowledge of residents and medication
3. However, to address the issue of medication errors the PIC’s will ensure the following
   • Ongoing spot checks of medication administration
   • Ongoing Medication audit
   • Medication updates to be highlighted at staff team meetings
   • Minutes to be circulated of meetings to all staff not present
   • A view to employ 1 full time Nurse
   • Ensure medication training is up to date for all nursing staff

Proposed Timescale: 30/04/2015

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents assessments did not consistently demonstrate health or social care needs.

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

Please state the actions you have taken or are planning to take:
1. Resident assessments are being reviewed for consistency by the PIC’s and staff nurses
2. The social histories, that were not evident at the time of the inspection, are being typed up for current care plans
### Proposed Timescale: 30/06/2015

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Not all residents had care plans reflected of their assessed needs.

**Action Required:**
Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident’s admission to the designated centre.

**Please state the actions you have taken or are planning to take:**
1. The PIC’s are in the discussion phase of changing care plans from the DML assessment tool, as it is evident that this tool does not encompass all aspects of holistic care.
2. Person in charge will look into new system assessment tool that further highlights the complex needs of our residents

### 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:**
Residents did not consistently have timely access to medical and health care required by their presenting symptoms.

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

**Please state the actions you have taken or are planning to take:**
1. To date we have had continuity of care with resident own GP. This system has left us dealing with as many as 13 GP’s. This may be a contributing factor in the findings of the report.
2. PIC have met with GP’s to who are considering taking on all or half of our residents as patients. This would enable residents and PIC’S to have a much more regulated response to resident needs.
3. We will expect GP’s to make a decision on this by March/April 2015

### Proposed Timescale: 30/04/2015
### 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 accommodation did not meet the needs of the residents;
- The communal accommodations was not suitable in size.
- Three of the double bedrooms did not provide sufficient space for the residents and meet requirements of the National Standards for 2015.
- There was insufficient dining space.
- The premises is in need of refurbishment and repair.

**Action Required:**
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

**Please state the actions you have taken or are planning to take:**
1. A new build has been designed and has been presented to the Authority
2. Planning permission has been sought form the Co.council and approved 26th Feb 2015
3. The Directors are currently in discussion with the bank to confirm further loan to support the build. Scheduled meetings with bank week commencing -9th March 2015

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

### Outcome 16: Residents' Rights, Dignity and Consultation

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

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

- There were no systems to support residents with communication difficulties to participate and communicate according to their capacity and needs.

**Action Required:**
Under Regulation 10(1) you are required to: Ensure that each resident, who has communication difficulties may communicate freely, having regard to his or her wellbeing, safety and health and that of other residents in the designated centre.

**Please state the actions you have taken or are planning to take:**
1. Dementia specific training will be sought for staff to support residents presenting with dementia.
2. Dementia specific best practise articles and ideas will be provided for staff in an ongoing basis through journal club.

**Proposed Timescale:** 31/08/2015

### Outcome 18: Suitable Staffing

**Theme:** 
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** 
Failing to ensure that all staff have access to appropriate training both mandatory and pertinent to the needs of the residents.

**Action Required:** 
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

**Please state the actions you have taken or are planning to take:**
1. All mandatory staff training is up to date
2. A Training matrix is established for management 2015
3. Further staff training pertinent to the needs of residents will be sourced
4. Staff training is highlighted in the staff appraisals
5. Behaviours that challenge will be addressed with ongoing memos articles
6. Following the inspection, Infection control training was completed by all staff. Feb/March 2015

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

**Theme:** 
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** 
Supervision systems were not satisfactory to ensure the delivery of care as detailed by resident needs and care plans.

**Action Required:** 
Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

**Please state the actions you have taken or are planning to take:**
1. A clinical management meeting will be held to discuss supervision systems in the delivery of care as per resident care plans.

**Proposed Timescale:** 30/03/2015