Health Information and Quality Authority
Social Services Inspectorate

Compliance Monitoring Inspection Report
Designated Centres under Health Act 2007

Centre name:	The Tower Nursing Home
Centre ID:	0110
Centre address:	94/95 Cappaghmore Clondalkin Dublin 22
Telephone number:	01 457 4209
Email address:	clondalkinnursinghome@live.com
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Clondalkin Nursing Home Ltd
Person authorised to act on behalf of the provider:	Patricia Robinson
Person in charge:	Aine Jones
Date of inspection:	13 November 2012
Time inspection took place:	**Start:** 09:20 hrs **Completion:** 17:00 hrs
Lead inspector:	Deirdre Byrne
Support inspector(s):	Sheila Doyle
Type of inspection	☐ **announced** ☒ **unannounced**
Number of residents on the date of inspection:	18
Number of vacancies on the date of inspection:	3

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 their 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
- 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 well-being 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. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Summary of 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, in which 10 of the 18 outcomes were inspected against. The purpose of the inspection was:

- ☐ to inform a registration decision
- ☐ to inform a registration renewal decision
- ☒ to monitor ongoing compliance with Regulations and Standards
- ☐ following an application to vary registration conditions
- ☐ following a notification of a significant incident or event
- ☐ following a notification of a change in person in charge
- ☐ following information received in relation to a concern/complaint

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

Outcome 1: Statement of Purpose	☐
Outcome 2: Contract for the Provision of Services	☐
Outcome 3: Suitable Person in Charge	☒
Outcome 4: Records and documentation to be kept at a designated centres	☐
Outcome 5: Absence of the person in charge	☐
Outcome 6: Safeguarding and Safety	☒
Outcome 7: Health and Safety and Risk Management	☒
Outcome 8: Medication Management	☒
Outcome 9: Notification of Incidents	☒
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 14: End of Life Care	☐
Outcome 15: Food and Nutrition	☒
Outcome 16: Residents' Rights, Dignity and Consultation	☐
Outcome 17: Residents' clothing and personal property and possessions	☐
Outcome 18: Suitable Staffing	☒

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

This was the fifth inspection of The Tower Nursing Home. The reports for this and previous inspections can be found at www.hiqa.ie. The purpose of the inspection was to assess compliance with requirements of 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. It was also to assess progress on the Action Plan from the inspection of 2 March 2012.

Since the last inspection the person in charge, Aine Jones had been on leave. The initial person who deputised for her had since resigned and a new deputising nurse was in place at the time of the inspection. The nurse deputising for the person in charge had been appointed the assistant director of nursing. Inspectors conducted a fit person interview with the new assistant director of nursing and found that she was knowledgeable about the Regulations and Standards, and the needs of residents in the centre.

Inspectors found that of the five action actions identified in the previous inspection, only one had been completed. There had been very little progress in the four other actions.

Inspectors found that the provider and person in charge were not complying with their regulatory duties in relation to the management of medication, the management of risk, the planning of residents' care, management of staff and volunteer records, the upkeep of the premises and provision of a suitable laundry room.

However, inspectors found that residents were cared for in a small, homely setting. The care they received was from staff who were patient and knowledgeable. The social needs of residents were being met and there was good choice in the meals provided.

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*.

Theme: Governance, Leadership and Management

Effective governance, leadership and management, in keeping with the size and complexity of the service, are fundamental prerequisites for the sustainable delivery of safe, effective person-centred care and support.

Outcome 3
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

References:
Regulation 15: Person in Charge
Standard 27: Operational Management

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Inspectors were satisfied the centre was managed by a person who was a suitably qualified and experienced nurse. The post of person in charge was full-time but was being filled by the assistant director of nursing until the person in charge returned to work full-time in the New Year following leave. The assistant director of nursing will be referred to as the person in charge for the remainder of this report because she was fulfilling that role while the person in charge was on leave.

The person in charge demonstrated sufficient knowledge of the Regulations and her statutory responsibilities. She was familiar with the residents and their care needs. She led a small team of staff who were also familiar with residents and their care needs.

The person in charge came to the centre during the inspection and told inspectors about her plans for improving the service on her return from leave. Prior to going on leave, she had completed a Education and Training Awards Council (FETAC) Level 6 management course. She had also participated in continuous learning and inspectors saw records of courses she completed in areas such as palliative care, behaviours that challenge and wound care. She told inspectors of her plans to introduce the learning from these courses into practice in the centre.

Theme: Safe care and support

Safe care and support recognises that the safety of service users is paramount. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers.

In a safe service, a focus on quality and safety improvement becomes part of a service-wide culture and is embedded in the service's daily practices and processes rather than being viewed or undertaken as a separate activity.

To achieve a culture of quality and safety everyone in the service has a responsibility to identify and manage risk and use evidence-based decision-making to maximise the safety outcomes for service users.

Outcome 6
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.

References:
Regulation 6: General Welfare and Protection
Standard 8: Protection
Standard 9: The Resident's Finances

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Inspectors were satisfied that the centre had measures in place to protect residents from being harmed or from suffering abuse. However, procedures for the safeguarding of residents' finances were not robust enough and required improvements.

A policy was in place for the prevention, detection and response to abuse. Inspectors reviewed the plan and found it gave detailed guidance. The person in charge was knowledgeable and clear of the procedures to implement in the event of an allegation or disclosure of abuse in the centre. Inspectors also spoke to a number of staff on duty and they were clear regarding the procedures to follow if they suspected or were informed of abuse. There had been training provided for staff in the centre. Inspectors saw training documentation which confirmed this.

Inspectors reviewed residents' finances and were not satisfied they were adequately safeguarded. There was no policy or procedure in place for the management of finances. Inspectors were told that individual sums of money were held in safeguarding for residents. These were kept in a locked box in a locked press at the nurses' station and nursing staff handled transactions. Inspectors reviewed the transactions for one resident. There was no receipt provided and there was one signature for some transactions and in one instance no signature at all. Inspectors counted the sum of cash held and it did not balance with the quantity written on the envelope.

Outcome 7
The health and safety of residents, visitors and staff is promoted and protected.

References:
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Inspectors saw policies and procedures on health and safety and risk management. However, improvements were needed in the identification and management of risk in the centre.

There was a health and safety policy in place. Inspectors reviewed the risk management policy and found that it did not meet the requirements of the Regulations as it did not cover the measures in place for specific risks such as self harm. The policy did not identify other risks pertinent to the centre such as risk of injury to residents who smoked and the risk of burning from hot running water. Inspectors found there were no arrangements in place for the investigating and learning from serious incidents involving residents.

Staff had up-to-date training in the moving and handling of residents, and were knowledgeable of best practice. Records seen by inspectors indicated that there were three dates in November 2012 for additional training.

An emergency plan was seen by inspectors that met the requirements of the Regulations. It included the alternative accommodation arrangements in place should the centre need to be evacuated. Inspectors spoke to a number of staff who were familiar with the plan and arrangements in place.

There were robust fire safety measures in place. A fire safety policy was seen by inspectors. Fire orders were prominently displayed throughout the centre and gave clear direction. Staff could tell inspectors about the fire fighting and evacuation procedures for the centre. Fire safety training had been carried out for staff and training records indicated that all staff had up-to-date training. Inspectors saw documented checks of fire exits, the fire panel and fire fighting equipment. Each was checked on a regular basis by staff. Service contracts were seen for the inspection and servicing of fire fighting equipment, fire alarm and emergency lighting. A fire drill was held every six months, with the most recent held for night staff on 8 November 2012.

Outcome 8
Each resident is protected by the designated centres' policies and procedures for medication management.

References:
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Inspectors were not satisfied that residents were protected by the centre's policies and procedures for the management of medication and areas of risk were identified by inspectors.

While there were policies and procedures for medication management, they did not fully provide clear guidance for staff. There were two versions of the medication policies in place. Inspectors also found that there were no procedures for the management of medication that required strict controls (MDAs) or for for the handling and disposal of medications.

The management of MDAs under the Misuse of Drugs (Safe Custody) Regulations 1984 was of concern to inspectors and there was a potential risk of medication error in this area. Inspectors reviewed the register of MDAs which included a record of a quantity of one drug still in stock, while the daily check sheet contradicted this with an unsigned record that stated the medication had been returned to the pharmacy. The records did not provide a clear account of MDA medications. It appeared that the controlled drugs register was being used to record the administration of controlled medications. One administration chart indicated that one MDA medication was not being administered in accordance with the prescription. The prescription stated that the medication should be administered every seven days but the records indicated that it was being administered every six to eight days. These matters were brought to the attention of the person in charge. Inspectors were later shown a faxed letter from the pharmacy confirming that the MDAs had been returned and were no longer in use.

Inspectors reviewed a number of residents' prescription/administration sheets. Nurses were not always administering medications as specified in the prescription. For example, some medications were prescribed for 8am, the administration record stated 6am but the medication was actually administered at 7am.

Inspectors found that recommendations made by a dietician to add supplements to a resident's diet had yet to be prescribed by the resident's GP. However, nurses had commenced administering the supplements without a prescription from the GP.

Outcome 9
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

References:
Regulation 36: Notification of Incidents
Standard 29: Management Systems
Standard 30: Quality Assurance and Continuous Improvement
Standard 32: Register and Residents' Records

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Inspector found that practice in relation to notifications of incidents was satisfactory.

There was a record kept of incidents and accidents in the centre with details of the type of accident and its location. Inspector found no incident or accident required notification to the Authority at the time of the inspection.

The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. To date all relevant incidents had been notified to the Chief Inspector by the person in charge.

Theme: Effective care and support

The fundamental principle of effective care and support is that it consistently delivers the best achievable outcomes for people using a service within the context of that service and resources available to it. This is achieved by using best available national and international evidence and ongoing evaluation of service-user outcomes to determine the effectiveness of the design and delivery of care and support. How this care and support is designed and delivered should meet service users' assessed needs in a timely manner, while balancing the needs of other service users.

Outcome 10
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

References:
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Action(s) required from previous inspection:

Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.

Inspection findings

Inspectors were not satisfied that the quality of care and experience of the residents were being monitored and used to improve the quality and safety of the service and the quality of life of residents.

There was no auditing system in place as yet in the centre. There was no evidence of any changes or improvements as a result of any reviews of care provided or review of the procedures.

Both the person in charge and deputising person in charge told inspectors they had attended clinical auditing training. Inspectors were told audits of falls had taken place, however, these were not available to inspectors. The person in charge stated that there were plans to introduce auditing, starting with areas such as hand washing, medication auditing and personal care. She said there were also plans to consult with the residents.

This had been an action in the previous inspection and the provider had not completed it within the agreed timeframe.

Outcome 11
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.

References:
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Action(s) required from previous inspection:

Provide a high standard of evidence-based nursing practice.

Inspection findings

Inspectors found that residents were receiving a good standard of care and had access to medical and allied healthcare. There were opportunities to participate in meaningful activities based on their interests and needs. However, improvements were required in the provision of evidence-based nursing care, documentation of care plans, consultation with residents and implementation of policies on wound care and behaviours that challenge.

There was good access to medical services with each residents being attended to by their own general practitioner (GP). There was out of hours and on call GP services also. Inspectors saw notes of GPs visits documented in residents' medical notes. Residents had access to a number of allied health care services such as dietician, chiropody, dentistry, and optometry and on a referral basis to physiotherapy, speech and language therapy (SALT) and occupational therapy (OT).

There was an admission assessment completed for each resident. A monthly assessment was carried out for areas such as blood pressure, weight, temperature, falls, and nutrition and dependency levels. Inspectors found that recognised assessments tools were being used and care plans were in place which were personal to each resident's needs. However, the date assessments were carried out was unclear as only the month was recorded. Some care plans did not have evidence of the consultation with the resident or their representative in their care planning.

Inspectors found the management of falls required improvement. Three files for residents at risk of falling were reviewed. A falls risk assessment was regularly completed for each resident and following each fall. However, one resident who had recently fallen and had been assessed as high risk of falls but there was no care plan in place to guide staff in the management of this risk. There was no falls diary in one of the files. The provider said it had been removed for review. Nursing staff carried out neurological observations following falls. However, the torch being used was too large and unsuitable for its purpose. Inspectors reviewed incident forms and found that there had been six falls in October. However, the provider had not undertaken an overall review or analysis of the occurrences of falls to identify areas for learning and improvement in the safety of residents.

The management of the use of restraint required improvement. A policy on restraint provided detailed procedures to follow. However, it had not been fully implemented in practice. One resident assessed for the use of bedrails had not been reassessed since May 2012. In addition there was no care plan in place to guide the appropriate care to be given. Inspectors saw that where restraint was used the alternatives to restraint were considered and residents' consent had been obtained. Restraint release forms were completed monitoring use and release of the restraint

Inspectors found that the management of wounds in the centre was satisfactory. However, the policy on wound management was in draft form and had not been implemented. Each resident was had a monthly skin integrity assessment completed and had a care plan for any issues that were identified. One resident had a wound at the time of the inspection. Inspector reviewed the resident's wound care plan and found that records were kept on the wound along with the details of the type of dressing used. These were kept in a separate folder referred to as a "daily recordings folder". Wounds were assessed for infection risk with samples sent to a laboratory for analysis. Inspectors read the resident's medical notes from the GP and referral letters to a vascular consultant for further review. Nursing staff were knowledgeable of the resident's wound care needs.

The management of behaviours that challenge was guided by policy. However, a new policy had been developed and had yet to be fully implemented into practice. Most staff had attended training and plans were outlined to inspectors of the new documentation to be used. It would allow staff to identify the triggers for certain behaviours and use this to inform the interventions to be put in place. Although not currently being recorded in care plans, staff were familiar with the residents' needs.

Residents were seen to enjoy the activities carried out in the centre. A part-time activities coordinator facilitated activities each afternoon from Monday to Friday. She told inspectors she got to know residents' individual needs by talking to and observing them. She had completed a questionnaire with each resident or their family. She was also in the process of making a photo album for residents and was working with families on this project. Residents could take part in group activities such as karaoke, quizzes and baking. For residents who were cognitively impaired, she would spend time on a one-to-one basis with them and would do the ladies nails, talk with the gentlemen and do quizzes. There had been a few outings arranged, with two recent trips to a local lounge bar. Another trip was planned for the following Friday to a local centre for a set dancing evening.

Outcome 12
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.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Action(s) required from previous inspection:

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.

Ensure the size and layout of rooms occupied or used by residents are suitable for their needs.

Inspection findings

Inspectors were not satisfied that the design and layout of the centre was meeting the residents' needs.

The inspectors were not satisfied that the new laundry arrangements in place met the needs of centre. While efforts had been made to address the lack of a suitable laundry room, the new facility was inadequate. It was located in a prefabricated building which had previously been used as a staff room. Three staff toilet cubicles remained in the room. However, there was no ventilated lobby separating them and the laundry area. The ceiling was bulging where a patrician wall had been removed.

There was insufficient storage and counter space for segregating clean and unclean clothes. There was inadequate storage of waste with bags of waste and bins stored in the room. A sink was provided, however, it had no running hot water supply. The interior of the building had not maintained to a good standard. The person in charge showed inspectors an email outlining discussion with an architect to address structural issues. In the previous action plan, the provider had stated that these issues would be addressed by August 2012.

Inspectors found that the carpet on the sitting room floor was in a worn condition. The wooden architraves of doors were chipped in places. The ceiling at the toilet on the ground floor was damaged from a leak, with the wires and plasterboard exposed from within. A plastered wall inside the upstairs assistive bathroom had not been finished with an easy to clean non absorbent material.

The bedrooms were pleasantly decorated, each with a functioning call bell. However, inspectors found one of the twin bedrooms did not have adequate storage space to meet both of the residents' needs. The residents were sharing one small wardrobe with no separate space provided. Inspectors found that there were two triple rooms. These bedrooms would not meet the requirements of the Authority's Standards by 2015.

The sitting room and small conservatory were pleasantly decorated. A small alcove in the sitting room had recently been created which gave further space for residents and had an additional TV.

A dining room adjacent to the sitting room was small in size and did not accommodate all residents at meal times. The person in charge told inspectors they managed this by arranging for two sittings at meals.

There were wash-hand basins in each bedroom and two assisted bathrooms on each floor. However, inspectors found that not all bathrooms doors were provided with locks to ensure residents' privacy. These matters were brought to the attention of the person in charge.

While hot water at each hand wash-hand basin was regulated by individual thermostats, inspectors found water at one hand wash-hand basin on the ground floor felt hot to touch and could pose a risk of scalding. This was brought to the attention of the person in charge, and immediately resolved.

There was assistive equipment provided for residents, with hoists, pressure relieving devices and wheelchairs available. Inspectors saw service contracts and records of regular inspection checks of the equipment. A chair lift was used to facilitate residents to move between the floors. It too was serviced regularly and records seen by inspectors confirmed this.

Protective aprons and gloves were available throughout the centre. There was good access to hand washing facilities. The inspector spoke with staff who were knowledgeable about infection control. Appropriate arrangements were in place for the disposal of clinical waste. The area around the outside waste skips had been

fenced off. There was one sluice room however it had not been equipped with a bedpan washer.

The centre was maintained to an adequate standard of hygiene. Inspectors met with a member of the cleaning staff. She was knowledgeable of cleaning procedures and infection control arrangement for the centre. There was appropriate cleaning equipment used and best practice was followed in cleaning, for example, the colour coding of cleaning cloths for different areas of the centre.

There were no suitable changing facilities in the centre for staff, as the previous facilities were now used as the laundry.

Theme: Person-centred care and support

Person-centred care and support has service users at the centre of all that the service does. It does this by advocating for the needs of service users, protecting their rights, respecting their values, preferences and diversity and actively involving them in the provision of care. Person-centred care and support promotes kindness, consideration and respect for service users' dignity, privacy and autonomy.

Outcome 15
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 discreet and sensitive manner.

References:
Regulation 20: Food and Nutrition
Standard 19: Meals and Mealtimes

Action(s) required from previous inspection:

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

Inspection findings

Inspectors were satisfied that residents received plenty of food and drinks, meals were wholesome and nutritious, in quantities as residents required, and served in an appetising manner and sociable atmosphere.

The nutritional needs of all residents were assessed and processes were in place to monitor residents' weights which were done monthly or more often as required. Residents who were assessed as being at risk were referred to a dietician for a review of their nutritional health. A food diary was completed prior to any review by a dietician.

There was access to fresh drinking water with a dispenser provided in the dining room. Residents were offered tea and coffee and other snacks throughout the day. Catering staff were observed asking residents what they wished to have for their lunch. There was good choice available at mealtimes including for residents on modified consistency diets.

The dining room was located adjacent to the sitting room. Meals took place over two sittings to meet all residents' needs. The size of the room is discussed in Outcome 12. Residents were observed chatting amongst each other and with staff during the meals. Some residents required support and were seen to receive assistance from staff in a calm and respectful manner.

The kitchen was seen by inspectors who also spoke to the chef. She had training in the management of food hygiene and was seen to follow best practices. There was a well stocked supply of fresh and frozen foodstuffs. Residents told inspectors they enjoyed the food.

Theme: Workforce

The workforce providing a health and social care and support service consists of all the people who work in, for, or with the service provider and they are all integral to the delivery of a high quality, person-centred and safe service. Service providers must be able to assure the public, service users and their workforce that everyone working in the service is contributing to a high quality safe service.

Outcome 18
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.

References:
Regulation 16: Staffing
Regulation 17: Training and Staff Development
Regulation 18: Recruitment
Regulation 34: Volunteers
Standard 22: Recruitment
Standard 23: Staffing Levels and Qualifications
Standard 24: Training and Supervision

Action(s) required from previous inspection:

Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory Information and documents specified in Schedule 2 of the Regulations have been obtained in respect of each person.

Inspection findings

Inspector found that further improvement regarding staff, volunteers and contracted service providers was required in order to meet the requirements of the Regulations.

A policy on recruitment was in place, it included a requirement for new staff to submit all documentation required by the Regulations. For example, inspectors reviewed four staff files but found they were not complete as there was no evidence of mental and physical fitness. This had been identified as a non compliance and the previous inspection and the provider had failed to complete the action required to address it.

Volunteers and external service providers attended the centre and provided valuable social activities and services. However, as yet there was no written agreement setting out their roles and responsibilities nor was appropriate vetting in place as required by the Regulations.

These issues were discussed with the person in charge and she was required to submit updated reports every two weeks till all documentation was in place.

Staff turnover was very low and most of the staff had worked in the centre for a number of years. They were knowledgeable about residents and the inspector saw them responding to residents' needs in an informed way.

The inspector confirmed that up to date registration was in place for nursing staff. The roster was reviewed and it reflected the staff on duty and the person in charge told the inspector that staffing levels were based on the number of residents and their dependency levels. The inspector was satisfied that there was sufficient staff on duty to adequately provide care to the residents.

Staff attended a broad range of training in areas that included wound care management, palliative care and managing behaviours that challenge. Training records were reviewed which confirmed this. Most care assistants had FETAC Level 5 training.

Closing the visit

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

Acknowledgements

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

Report compiled by:

Deirdre Byrne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

16 November 2012

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report *

Centre Name:	The Tower Nursing Home
Centre ID:	0110
Date of inspection:	13 November 2012
Date of response:	27 December 2012

Requirements

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

Theme: Safe care and support

Outcome 6: Safeguarding and safety

The provider is failing to comply with a regulatory requirement in the following respect:

The safeguarding measures in place to manage residents' personal finances were not robust enough to ensure accountability and transparency of all transactions.

There was no policy in place to guide staff in the management of residents' finances.

The provider had not ensured that the recorded balance of residents' finances were accurate.

Action required:

Put in place all reasonable measures to protect each resident from all forms of abuse.

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

Action required: Put in place a policy on and procedures for the prevention, detection and response to abuse.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 8: Protection Standard 9: The Resident's Finances	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: In order to address issues of accountability and transparency, we have created a finance book, which has written accounts of all transactions by staff and residents/family members. Each resident has a personal sheet with the following information: Date Cash amount in/out Reason for balance Two signatures family and staff/nurse on duty Receipts These accounts will be audited and signed off each week for the purpose of accuracy by person in charge and staff nurse on duty each Friday. There is also a sign in/out sheet for any other monies left for management as payment of fees or services not included in fees. There is a written procedure in place attached to this book which guides staff in dealing with resident monies. Staff will read the procedure and sign that they understand same.	Completed 28/12/2012 28/12/2012 31/12/2012

Outcome 7: Health and safety and risk management

The provider is failing to comply with a regulatory requirement in the following respect: The risk management policy did not cover the following: ▪ the identification and assessment of risk in the centre for all hazards such as smoking and a hot water supply ▪ the precautions in place to control specified risk such as self harm ▪ the arrangements in place to control and manage the risk of serious or untoward incidents or adverse events involving residents.

Action required:

Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

Action required:

Ensure that the risk management policy covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm.

Action required:

Ensure that the risk management policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

Reference:

Health Act, 2007
Regulation 31: Risk Management Procedures
Standard 26: Health and Safety
Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
The risk management policy was updated in February 2012 and covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence.	Completed
We have included the policy on self-harm as of November 2012	Completed
The risk management policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents. This recording sheet is attached to the Risk management policy	Completed
A "serious incident review form" has been created and included in the risk management policy document to identify, record, investigate and learn from serious or untoward incidents or adverse events involving resident.	Completed

Outcome 8: Medication management

The provider is failing to comply with a regulatory requirement in the following respect:

The medication management policy did not provide direction to nursing staff on the management of medications that require strict controls (MDAs) and there were no guidelines for the handling and disposal of unused or out of date medications.

The practices in place to manage the storage and administration of medications requiring strict controls (MDAs) were not carried out in line with best practice.

The administration time for some medications was not carried out in accordance with the prescription.

Drug discrepancies were not being recorded resulting in increased risk of medication error

A food supplement was administered to a resident although it had yet to be prescribed.

There were two policies in place for medication management which was not appropriate to ensure standard practice was being implemented.

Action required:

Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

Action required:

Put in place suitable arrangements and appropriate procedures and written policies in accordance with current regulations, guidelines and legislation for the handling and disposal of unused or out of date medicines and ensure staff are familiar with such procedures and policies.

Reference:

Health Act, 2007
Regulation: 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

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

Provider's response: Our medication policy is in the process of being updated. All Nursing staff will be familiar with the new policy. This includes handling and disposal of unused or out of date medicines, and ordering, prescribing, storing and administration of medicines. Regular audits will take place to evaluate if the practices of our Nurses are in accordance with our policy. New drug administration records sheets have been ordered from the printers. These new record sheets have several changes. These include added administration times, this is to ensure that medications are given at correct and appropriate times. And that error in administration times will be eliminated.	 31/12/2012 31/12/2012 05/01/2013

Theme: Effective care and support

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

The provider is failing to comply with a regulatory requirement in the following respect: There was no auditing system in place to review the quality of the service and the quality of life and safety of the residents.	
Action required: Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.	
Reference: Health Act, 2007 Regulation: 35: Review of Quality and Safety of Care and Quality of Life Standard 30: Quality Assurance and Continuous Improvement	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A new system of auditing has been introduced. These audits are designed to collect information and use this information to enhance the quality of life for our residents. We have created a resident bi annual survey in order to review our quality of service. This survey records information under the following headings Personal satisfaction, Nutrition, Health,	 31/12/2012 31/12/2012

Services, Access, Personal likes, Personal care, Complaints. We have also created a resident questionnaire which is an aid to understanding the resident likes and interests. This questionnaire has been completed by residents. The information gathered allows the staff to arrange activities that suit residents throughout the year	Completed

Outcome 11: Health and social care needs

The provider is failing to comply with a regulatory requirement in the following respect: The equipment used for neurological observations was inappropriate with staff using a large torch not suitable for this purpose.
Action required: Provide a high standard of evidence-based nursing practice.
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 13: Healthcare Standard 18: Routines and Expectations

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The neurogical observations are being carried out using an appropriate small torch. Each nurse will be provided with a torch for neurological observations Each nurse will be knowledgeable about Neurological Observations	 Completed 31/12/2012 31/12/2012

The person in charge is failing to comply with a regulatory requirement in the following respect: The date when assessments of residents' needs were completed only indicated the month. While most residents or representatives were involved in their care planning there was no evidence of consultation with some residents.

One resident assessed as high risk of falling did not have a care plan in place to guide the care to be given. Centre specific polices on wound care and management of behaviours that challenge had been developed but were not being used by staff in the assessment process and care planning to meet residents' needs.	
Action required: Set out each resident's needs in an individual care plan developed and agreed with the resident.	
Action required: Make each resident's care plan available to each resident.	
Action required: Revise each resident's care plan, after consultation with him/her.	
Action required: Notify each resident of any review of his/her care plan.	
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 3: Consent Standard 10: Assessment Standard 11: The Resident's Care Plan Standard 17: Autonomy and Independence	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Assessment documentation has been changed to allow the assessor to record the actual date the assessment was performed and not just the month in which it was performed. This new documentation will commence in the new year as the old documentation will be completed at the end of the year We have arranged for family meetings to commence in January 2013. Care plans will be discussed at these meetings and resident and family involvement will be recorded	01/01/2013 31/01/2013

The wound care policy will be rolled out in January 2013. New documentation has been introduced, although after a one month trial we have decided as a team to alter the documentation. New documentation will commence in January 2013. The policy on behaviours that challenge will be rolled out in January 2013. Care plans will reflect care interventions and promote the safety and well being of our residents Challenging behaviours will be assessed as per policy guidelines	01/01/2013 01/01/2013 01/01/2013

Outcome 12: Safe and suitable premises

The provider is failing to comply with a regulatory requirement in the following respect: The premises did not meet the requirements of the Regulations: ▪ the laundry room was not adequate for the management of residents' laundry and management of infection control ▪ there was no suitable staff changing facilities provided ▪ parts of the centre were not maintained to a good standard of repair ▪ there was insufficient personal storage space provided for residents in a twin bedroom ▪ the size of the dining was not large enough to accommodate all residents.
Action required: 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.
Action required: Provide suitable changing and storage facilities for staff.
Action required: Ensure the size and layout of rooms occupied or used by residents are suitable for their needs.
Action required: Ensure the premises are of sound construction and kept in a good state of repair externally and internally.
Action required: Provide suitable storage facilities for the use of each resident.

Action required: Provide adequate dining space separate to the residents' private accommodation.	
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We acknowledge that the premises does not meet the requirements of the regulations. We have been consulting with an architect since May 2012 to design an extension to incorporate a new laundry room, larger dining room and larger lounge room. The plans should be available early 2013. Work is to begin once the planning permission is granted. Internal maintenance is continuous. The lounge room has been freshly painted. The carpet has been steam cleaned. New storage space for one of our residents shall be bought	March 2013 Completed 01/01/2013

Theme: Workforce

Outcome 18: Suitable staffing

The provider is failing to comply with a regulatory requirement in the following respect: Staff files did not contain all of the documentation required in the Regulations to indicate staff were fit to work in the centre.
Action required: Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 of the Regulations have been obtained in respect of each person.
Action required: Set out the roles and responsibilities of volunteers working in the designated centre in a written agreement between the designated centre and the individual.

Reference: Health Act, 2007 Regulation 18: Recruitment Standards 22: Recruitment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Staff files have been updated with all staff requested to bring in a fit for work declaration from their GP. As of today 11 staff members have not returned their fit to work declaration from GP. Recruitment policy and procedure states that no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 of the Regulations have been obtained in respect of each person. The roles and responsibilities of volunteers is written and made available to all volunteers. In addition to this we have included a written agreement between management at the Tower Nursing Home and the volunteer.	01/12/2013 Completed Completed

The person in charge is failing to comply with a regulatory requirement in the following respect: Volunteers and outsourced providers files did not contain garda vetting and a written agreement of their role and responsibilities.
Action required: Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 of the Regulations have been obtained in respect of each person.
Action required: Ensure volunteers working in the designated centre are vetted appropriate to their role and level of involvement in the designated centre.
Reference: Health Act, 2007 Regulation 34: Volunteers Standards 22: Recruitment

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Volunteer and work experience guidelines are in place in the Human Resources policy since February 2012. In addition to this we have created a written agreement of the role and responsibilities for signature. We have added this procedure to the human resources policy recruitment procedure to ensure no volunteer is taken on to work at the tower Nursing Home unless the person has been vetted appropriate to their role and level of involvement in the designated centre.	 Completed Completed

Any comments the provider may wish to make[1]:

Provider's response:

As mentioned in the report, the person in charge was on leave for six months post registration with the Authority. A deputy person in charge was appointed to take her place. Unfortunately for the Nursing Home, the deputy person in charge did not continue her employment and resigned after three months. The person in charge returned to her post and a new deputy was appointed. With all these changes taking place, the momentum that we had prior to registration was lost. We are now once again pro-active in achieving our goals and wish to thank the Authority for recognising this. We are happy that the inspectors commented on how well our residents are cared for. We strive to keep the Tower a small homely environment for our residents, and we wish to continue this in the future.

Provider's name: Patricia Robinson/Aine Jones
Date: 27 December 2012

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