

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	The Tower Nursing Home
Centre ID:	OSV-0000110
Centre address:	94/ 95 Cappaghmore, Clondalkin, Dublin 22.
Telephone number:	01 457 4209
Email address:	clondalkinnursinghome@live.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Clondalkin Nursing Home Limited
Provider Nominee:	Patricia Robinson
Lead inspector:	Valerie McLoughlin
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	21
Number of vacancies on the date of inspection:	0

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 decision. This monitoring inspection was unannounced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 21 October 2015 12:00 To: 21 October 2015 17:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This unannounced, one day inspection was the tenth inspection of this centre. The purpose of the inspection was to follow up on the required actions from the previous inspection that took place on 03 February 2015 and to inform the decision of the Authority in relation to the application by the provider to renew the registration of the centre.

The outcome of the inspection in February 2015 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 on the inspection in February, nine had been satisfactorily completed and actions had been taken in relation to ten other non compliances identified.

The management team were committed to meeting the needs of residents and provided a good quality service. The provider had made significant improvements since the previous inspection. The outcome from this inspection demonstrated that

the provider had worked hard to meet the requirements of the regulations. Eleven of the required actions had been completed, two were progressed but not completed. While some improvements had been made to the premises, the planned building works to extend bedrooms and communal space in order to meet the requirements of the regulations had not started.

Overall, residents' healthcare and nursing needs were met to a high standard. Residents had access to medical, allied health and psychiatry of later life services.

The provider and person in charge promoted the safety of residents. Recruitment practices met the requirements of the regulations. Staff had received training and were knowledgeable about the protection of vulnerable adults and how to respond to and report any suspicion or allegation of abuse and other relevant areas. Residents had access to advocacy services.

There were adequate staff on duty and staffing arrangements facilitated continuity of care. Staff had mandatory training as well as additional relevant training. The provider had invested in staff training and staff were knowledgeable and focused on meeting residents' needs. Staff respected the privacy and dignity of residents. While the social needs of many residents were met, improvement was required to promote more effective communication strategies for residents with cognitive impairment and dementia.

Previous inspections found the space in two twin rooms was inadequate, and communal space was limited. Since the previous inspection the provider had obtained planning permission for renovation of the existing centre and an extension to one side and to the back of the centre to meet the requirements of the regulations. The provider planned to maintain the current number of places in the new build at 21 places. Each resident would have their own bedroom, separate dining and sitting rooms and continued access to a secure back garden. At the time of inspection the provider was in the process of applying for funding for the works.

Some areas for improvement are required and are included in the action plan at the end of the 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:

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 centre's statement of purpose, and the manner in which care is provided, reflect the different needs of residents. It contains all of the information required by Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The Authority received an updated copy of the statement of purpose in March 2015. Staff are familiar with the statement of purpose and the statement of purpose is clearly implemented in practice.

Judgment:

Compliant

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

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

Findings:

The inspector found that 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

There is an effective system of clinical governance in place and this is being further developed by the management team on an on-going basis. The clinical governance team meet monthly to discuss where improvements can be made in clinical care, risk management and resident satisfaction for example. In addition to carrying out monthly clinical audits the team also focused strongly on areas for improvement identified in their quality and safety improvement action plan and also on the required actions from the previous inspection.

The inspector read a number of audit reports such as falls prevention and management, medication management and infection control for example. Quality improvement measures had recently been put in place such as the purchase of an upgraded housekeeping cleaning system recently. This included the provision of new hand cleansing gels throughout the centre. Staff had been provided with further training on infection control issues resulting in improved audit results.

Regular environmental audits and health and safety walk about were also carried out and the results reviewed by the management team and any trends identified, shared with staff, rectified and monitored. Since the previous inspection the provider had a system in place to complete the annual quality and safety review of services and was collating the information on a quarterly basis. For example, information about the number of admissions, deaths, falls, notifications, complaints; satisfaction surveys, refurbishment and audit results. The provider was aware that the review would need to be available in January 2016 should the Chief Inspector request a copy.

There was evidence that a number of improvements had already been implemented, such as replacement of the carpet in the sitting room, installation of a new fire safety management system and additional staff training. There was evidence of formal and informal consultation with residents and representatives, and their feedback was used to improve the service. For example, activities had been revised to include more one to one time with residents with dementia and or cogitative impairment.

Judgment:

Compliant

Outcome 04: Suitable Person in Charge

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

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.

Both are engaged in the governance, operational management and administration of the centre on a regular and consistent basis. They had a system in place to ensure effective communication relating to the care of residents and the management of the centre are in place to ensure consistency of approach.

The inspector saw detailed handover documentation that included information such as any change in the residents' condition, appointments attended and scheduled, communication with families, staffing, and maintenance issues.

Both had the relevant experience required by the regulations and had attended all mandatory training. On the day of inspection, one of these nurses was on duty and provided all of the required information to the inspector in a timely manner. The inspector found that she had very good clinical knowledge and knew the residents very well. Clear job descriptions outlining various roles had been devised. Reporting systems with the provider were in place at a formal and informal level.

Judgment:

Compliant

Outcome 07: Safeguarding and Safety

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

Theme:

Safe care and support

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

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

Findings:

The inspector found that measures were in place to protect residents from being harmed or abused. The person in charge demonstrated good knowledge of the management and investigation of all forms of abuse. A number of improvements had been put in place since the previous inspection to ensure that residents safety was promoted. For example, staff had received additional training on any suspicion of abuse, recognition of abuse and the correct procedure for reporting. Therefore this aspect of the action plan had been met.

Additional training was scheduled for the remainder of the year. A centre-specific policy was available which gave guidance to staff on detection, reporting and investigation of any allegation of abuse. Staff interviewed demonstrated good knowledge of the policy.

A review of incidents since the previous inspection showed that there were no allegations of abuse in the centre.

Residents spoken to commented that they felt safe and secure in the centre. Residents said this was because the staff were kind and caring and were readily available if they needed anything.

The systems in place to safeguard resident's money were monitored on the previous inspection and stringent systems were found to be in place in line with the policy. The person in charge had a system of weekly audit of the small amounts of monies kept in safekeeping for residents. This was recorded in the person in charges weekly handover meetings, and stored safely to maintain confidentiality. The inspector noted that all of the accounts were in balance.

Call bells were available in each bedroom and the inspector observed that staff answered them promptly.

There was a policy on and procedures for managing behaviours that challenge. The previous inspection found that while care plans were implemented in terms of the most supportive strategies to use in managing these behaviours the plans were not consistently implemented by staff. Since the previous inspection all staff had received additional training on how to respond to and manage this behaviour. The nurse in charge told the inspector of improvements in one residents' behaviour in previous months following implementation of a positive support plan. The plan had been implemented following reviews by the consultant psychiatrist of older age and the clinical nurse specialist. The inspector saw that there was a behaviour support plan in place to guide staff on how to communicate with the resident and provide appropriate supports. Evidenced based guidelines were adhered to in the management and recording of behaviour.

Staff spoken with demonstrated good understanding and knowledgeable in how to support residents, as outlined in the care plan. The person in charge reviews the care plans on a regular basis to ensure that the care is consistently implemented. There was

recorded evidence that residents were reviewed regularly by the consultant psychiatrist of old age and the recommendations from the positive support plan were implemented. Therefore this aspect of the action had been addressed.

The use of restraint was in line with the national policy on restraint. Since the previous inspection improvements had been put in place such as the implementation of a more comprehensive risk assessment tool which included a record of the residents' cognitive status. The rationale for use was clearly documented and where possible alternatives trialled prior to the implementation of restraint. Risk assessments and a care plan were in place to guide evidenced based practice. Therefore this aspect of the action plan had been met.

There was a system in place to monitor residents and the practice of restraint was subject to regular audit and three monthly reviews by the multidisciplinary team. The person in charge showed the inspector the quarterly audit report which demonstrated 100% compliance in adherence to the policy on the management of restraint. The person in charge was working towards a restraint free environment. For example the team had achieved a 50% reduction in the use of bedrails to date this year. There was very limited use of PRN (as required) medications. An audit of the use of psychotropic medications had been undertaken in June 2015 and six residents were reviewed by the psychiatric of old age. The inspector noted that the last time one resident received a PRN medication was in April 2014.

Judgment:

Compliant

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:

The inspector found that there were effective systems and processes in place to promote the health and safety of residents, staff and visitors. Since the previous inspection the inspector found that a number of improvements had been made and all of the required actions had been met.

There was a centre-specific, risk management policy which addressed all the risks specified in the regulations as well as the procedures in place for the identification and management of risk.

A safety statement was in place and it related to the health and safety of residents, staff

and visitors. There was a risk register in place which was reviewed by the clinical governance team on a regular basis. The previous inspection found that it did not include clinical risks of relevance to the residents such as the risk of developing pressure sores or medication errors. The inspector reviewed the risk register and found that it now included clinical risk issues and control measures to mitigate the risk of future occurrences.

Arrangements were in place for investigating and learning from incidents and the inspector reviewed the last meeting of the governance committee. This included a review of incidents and accidents, such as falls, wound care practice and pressure ulcer prevention and management. For example, following identification of risk of falls, measures were implemented to minimise the risk of falls and the risk of harm to residents, such as the use of low-low beds and crash mats where appropriate, ensuring walk-ways were unobstructed and a medical review to rule out any clinical underlying contributory factor such as referral to ophthalmology. The management of clinical risks in relation to wounds had improved with the introduction of a new evidenced based wound assessment and management template. Also a pressure ulcer prevention and management review resulted in a review of the maintenance of alternating pressure relieving mattresses.

The inspector reviewed the emergency plan and found that it provided sufficient guidance to staff on the procedures to follow in the event of an emergency. All residents had an individual evacuation plans developed. Staff spoken with were familiar with the policy.

Recruitment practices met the requirements of the regulations and all staff were up to date on manual handling training. The inspector observed safe manual handling practices, such as assisting residents into and out of their chair safely and ensuring that the brakes were used prior to assisting a resident to transfer. Care plans were in place for each resident for the safe use of the hoist, including preserving the residents' dignity during transfer.

Improvements had been made since the previous inspection. The previous inspection showed that there was no documentary evidence that the panel of relief staff had undergone training in moving and transporting residents. The person in charge showed the inspector the training records for the relief staff. The inspector was satisfied that this aspect of the action plan had been met.

Overall fire safety was well managed. The provider had recently upgraded the fire safety management system. The inspector viewed the fire training records and found that all staff had received up-to-date mandatory fire safety training and this was confirmed by staff. All staff spoken to knew what to do in the event of a fire and regular fire drills were carried out by staff at suitable intervals as defined by the regulations.

The inspector viewed the fire records which showed that fire equipment had been regularly serviced. The fire alarm had been serviced quarterly. The inspector found that all internal fire exits were clear and unobstructed during the inspection. There was recorded evidence that furniture and fittings are fire retardant.

The inspector found that improvements had been put in place following the previous inspection. For example, a ski evacuation sheet was now available for each resident, should an evacuation of the building be required. All staff were trained in the use of ski sheets to evacuate and mock evacuations had taken place. Since the previous inspection evacuation plans were put in place for residents detailing their individual mobility needs in the event that this was required. The previous inspection found that the exit doors were locked by key at night and not all staff carried the keys to the doors which could place residents at risk as the keys were not secured at the exits. The inspector spoke to the person in charge and effective arrangements were in place as staff had been provided with keys. Therefore all of the required actions had been met.

Procedures were in place to protect residents who smoke. Smoking was not permitted inside the building and an external smoking area was provided and accessible to the residents in a secure garden. Individual risk assessments were carried out for the residents who smoked in order to determine their ability to smoke independently or with assistance. Some residents did not require supervision. There was a fire blanket in place and all staff had been trained in the use of fire blankets and fire extinguisher. The inspector found that there was no emergency call bell located in the smoking area, should a residents clothing catch fire. The person in charge said that she would ensure one was installed as a matter of urgency.

The inspector found that there were measures in place to control and prevent infection. Staff were knowledgeable in infection control. Staff had access to a plentiful supply of gloves, disposable aprons and alcohol hand gels, all of which were available discretely throughout the centre. As previously mentioned a new colour coded housekeeping cleaning system had recently been implemented and staff training provided on the new system.

Judgment:
Substantially Compliant

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

Findings:
The previous inspection outlined some concerns that staffing impacted on the safe administration of medication. While these had been managed promptly and appropriately, and there had been no ill effects on the residents the type of error or near miss suggested 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.

The inspector spoke with the person in charge and reviewed the staffing and skill mix and found staffing arrangements to be satisfactory. The person in charge told the inspector that since the previous inspection they maintain consistency in scheduling relief staff that are familiar with the residents' needs and medications. In the event of unscheduled sick leave the person in charge said that she would provide coverage on night duty within her nursing role. She explained that this also assisted her to maintain her nursing skills and to monitor care. She explained that this was not a regular occurrence.

There was a system in place for regular audit of medication management and regular reviews by the GP and pharmacist. The inspector reviewed the audits completed for March, July and September 2015 and found improved compliance. Weekly spot checks were also completed by the person in charge. A blister pack administration system had been implemented and the person in charge attributed this to reduced errors and near miss. All staff were up to date in medication management, training had been provided in February and July 2015. There was a medication management policy in place and staff were familiar with it. At the time of inspection the policy was in the process of being revised to include the 10 rights of safe medication practice.

Judgment:

Compliant

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:

To date and to the knowledge of inspectors, all relevant incidents had been notified to the Chief Inspector.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

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

Findings:

The inspector was satisfied that residents' healthcare needs were met to a high standard and that each resident had opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. Residents had access to GP services and a full range of other services was available on referral including speech and language therapy (SALT) and dietetic services. Occupational therapy was available on a referral basis. Chiropody, dental and optical services were also provided. The inspector reviewed residents' records and found that residents had been referred to these services and the recommendations from these services had been implemented and monitored. For example, food and fluid records were maintained when required, and blood tests were obtained at the specified intervals and results monitored by the GP.

The person in charge told the inspector that the provider had plans to move to a computerised system of assessing, planning and recording care on completion of the new build. The inspector noted that space on the assessment tool was limited but it did capture a holistic overview of the residents needs. The person in charge acknowledged that the assessment tool would require further development to enable additional information to be recorded. Where needs were identified an evidenced based care plan was in place. Care plans reviewed were reflective of the residents' current status.

The person in charge met and assessed residents prior to admission to ensure that the placement was suitable and also to ensure that all relevant information and equipment was available prior to admission to support the resident. Perspective residents and their family were invited to visit the centre prior to admission.

Multidisciplinary discharge information from acute hospitals was also available within residents' files, and this information was used to inform the assessment and care planning process. For example, recording of past medical history and up to date information from the speech and language therapist.

A review of medical files demonstrated that the general practitioner (GP) reviewed residents within forty-eight hours of admission. This had been a requirement from the

previous inspection. Therefore this aspect of the action plan had been met.

The inspector reviewed a sample of residents' nursing notes and found that nursing assessment and additional clinical risk assessments were carried out for residents on admission and care plans put in place within forty-eight hours from admission. Reassessment and care plans were reviewed every four months or more frequently if there was a change in their condition.

Validated risk assessment tools were used to determine residents at risk of falls, risk of malnutrition and dehydration, risk of developing pressure ulcers and risks associated with manual handling, and level of cognitive impairment. The care plans viewed were evidenced based and would guide care. There was recorded evidence of family involvement in the care planning process.

There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. There were policies on nutrition and hydration which were being adhered to and supported good practices. Residents were screened for nutritional risk on admission and reviewed every three months. Residents' weights were checked on a monthly basis, and weekly when indicated. Food and fluid charts were maintained for three days to determine residents' nutritional and fluid intake. Appropriate nutritional care plans were in place that detailed residents' individual food preferences, and outlined the recommendations of dieticians and speech and language therapists where appropriate. The dietician was reviewing residents in the centre on the day of inspection. Nutritional and fluid intake records, when required were appropriately maintained. Residents were offered a variety of drinks and snacks during the day. There were no residents experiencing weight loss or dehydration on the day of inspection.

The inspector observed that residents were offered a choice of meals. Residents told the inspector that if they changed their mind at meal time, an alternative was provided. Staff were observed providing assistance to residents, chatting to them and pacing the meal appropriately. Residents described the food as, "excellent" and "plentiful". An up to date list of specialised meals was in place, such as residents requiring high protein or modified consistency diets and thickened fluids. The inspector noted that residents received the correct diet and modified meals were attractively served.

There was very good supervision of residents in communal areas and the staffing levels on the day of inspection were satisfactory to ensure that resident safety was maintained. There was a policy in place on the prevention and management of falls to guide staff. Records reviewed indicated that the GP reviewed residents who had a fall and the family were appropriately informed. Staff spoken with confirmed this was their practice. Residents at high risk of recurrent falls are referred to the falls management clinic.

Additional supervision was provided when residents choose to spend time in their bedrooms during the day, and staff check residents two hourly overnight.

There were no pressure ulcers or wounds in the centre. An evidence-based wound care / pressure ulcer prevention policy in place policy was used to guide practice. Staff spoken to were knowledgeable of the strategies to be taken to prevent pressure ulcers and skin integrity checks were recorded daily. This had been a requirement from the

previous inspection. Therefore this aspect of the action plan had been met. Records were maintained to demonstrate that residents were assisted to change position regularly to minimise the risk of pressure ulcers. Alternating pressure relieving mattress and specialised cushions were available and used where indicated.

The inspector observed staff communicating with residents in a respectful and caring manner. Staff knew the residents well and many residents knew the staff by name. It was apparent that the residents and staff had a good relationship and staff were seen to join in the activities and were observed sitting chatting with residents.

There were arrangements in place to review accidents and incidents within the centre, and residents were regularly assessed for risk of falls. Care plans were in place and following a fall, the risk assessments were revised, medications reviewed and care plans were updated to include interventions to mitigate the risk of further falls. However, the date were not always recorded when a care plan had been reviewed or amended. This was not in line with professional nursing guidelines also made it difficult to measure the effectiveness of an intervention.

Judgment:

Substantially Compliant

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):

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

Findings:

The premises are located in a mature, quiet housing estate close to Clondalkin village. The inspector found that the centre was warm, clean and it had a homely atmosphere. Structural improvements are required to ensure it meets the needs of the residents and complies with the national standards. The premises in general were in need of refurbishment including painting and replacement of some flooring. While awaiting the extension works, the provider was constrained somewhat in relation to replacing carpets and decorating the premises. However since the previous inspection the provider had made the following improvements to the premises:

- Installation of a new chair lift
- Purchase of a new housekeeping colour coded cleaning system and new hand gel

dispensers

- Provision of ski sheets for all beds
- Installation of a new fire safety management system and new fire doors
- Picture/word signage on communal doors
- The sitting dining room had been redecorated with new carpet.

Provided lamps to improved internal lighting.

The premises are comprised of a combined dining and day room, where residents spent their day. The dining area is not large enough and had seating for twelve residents and two sittings were held for meals.. 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 two 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.

Two 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 person in charge 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 stairs and a chairlift.

Residents have access to a well maintained, secure garden.

The provider advised the inspector that there is a definitive plan in place to address the deficits in the premises. The provider secured planning permission and is awaiting approval for funding.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

The inspector found that staff communicated with residents in a kind, caring and patient manner. Resident were consulted about the running of the centre and residents had access to advocacy services. The person in charge supported a resident to access this service to enable him/her to move back home.

The inspector noted that residents had communication care plans in place to guide staff in communicating with residents with dementia or cognitive impairment. However, these care plans could be further improved to guide more effective methods of communicating for residents with dementia and residents who are non-verbal. For example with the use of alternative communication aids such as word/picture aids and information technology. This had been a requirement from the previous inspection and the action had only been partially met. The person in charge acknowledged that they had some work to do to improve this aspect of care. The person in charge had attended a short course to gain more insight into meeting the needs of residents with dementia related conditions. She explained that the management team do have plans for additional staff training by the end of the year to ensure that these residents' communication needs are met consistently.

Judgment:

Non Compliant - Moderate

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 inspector found that the current staffing levels, qualifications and skill mix were appropriate for the assessed needs of residents. Residents and staff agreed that there were adequate levels of staff on duty. Since the previous inspection the staffing compliment for nurses increased from 3.5 whole time equivalent (WTE) to 4.66 WTE. The provider submitted the updated statement of purpose in March 2015 to reflect this new information.

The person in charge told the inspector that they use regular part time staff to ensure a consistent and safe approach to care of the residents. A review of the rota indicated that the same staff are utilised on a regular basis. If however, a nurse is unable to come on night duty as scheduled the person in charge provides coverage within her role as person in charge. She said that this was not a regular occurrence.

Resident dependency was assessed using a recognised dependency scale and the staffing rotas were adjusted accordingly. Some dependency levels were high to maximum at the time of inspection.

The inspector found that there were procedures in place to ensure that residents in communal areas were appropriately supervised.

The nurse in charge and the provider placed strong emphasis on training and continuous professional development for staff. Staff spoken with told the inspector that they felt well supported by the nurse in charge and the provider. Staff retention was good and staff appeared to get along very well with the residents and with each other.

Staff told the inspector they had received a broad range of training which included falls prevention, protection of older adults, nutrition, wound care, pressure ulcer prevention, cardiopulmonary resuscitation and first aid (CPR), infection control, dementia care, dysphagia, medication management and activity provision for residents.

The person in charge ensured that all staff were up to date with their mandatory training. The inspector noted that training had been scheduled for the following day and for remainder of the year.

Care assistants had completed Further Education and Training Awards Council (FETAC) level five or above. The nurse in charge regularly reviewed the training files to ensure all staff attended relevant training and refresher updates.

There was a recruitment policy in place and the inspector were satisfied that staff recruitment was in line with the regulations. A sample of staff files were examined and the inspector noted that all relevant documents were present. The inspector reviewed a sample of files and found that nursing staff had up to date registration with An Bord Altranais agus Cnáimhseachais na Éireann (Nursing and Midwifery Board of Ireland) for 2014 and this was being progressed for 2015. There were no volunteers working in the centre, the nurse in charge was aware of the vetting procedures required by the regulations should they utilise volunteers in the future. The inspector found that improvements had been made since the previous inspection in verifying references. The inspector found that there was recorded evidence on file indicating that staff references had been verified. Therefore this action had been met.

Staff told the inspector there were open informal and formal communication within the centre to discuss issues and residents needs as they arose.

The inspector reviewed minutes the staff meeting 25 September 2015. Areas for discussion included policies, audits, infection control, training, medication management, meal breaks, and the menu and staff involvement in activities for all residents.

The person in charge was observed to be involved in the daily activities in the centre. The person in charge provided supervision of staff and residents on a daily basis. The inspector observed the person in charge to communicate well with residents and staff. Residents knew the person in charge by her first name, and residents said that she was very helpful and approachable.

Staff were supervised appropriate to their role. The person in charge met formally with staff to discuss their progress, any issues or training needs. There was evidence that training needs requested by staff had been met, such as achieving competency in phlebotomy, for example.

Staff spoken with were familiar with the policies and procedures in place, the regulations and the standards and the areas for improvement required from the previous inspection.

Judgment:
Compliant

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:

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Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	The Tower Nursing Home
Centre ID:	OSV-0000110
Date of inspection:	21/10/2015
Date of response:	18/11/2015

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 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

There was no emergency call bell located in the smoking area..

1. Action Required:

Under Regulation 28(2)(ii) you are required to: Make adequate arrangements for giving warning of fires.

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. An emergency call bell has been installed in the outdoor smoking area, which is linked to 3 warning panel locations in the building, to give a warning to staff, as of Monday 16th Nov 2015.
2. All Staff will be informed of the location and warning code number of the the emergency call bell by Friday 20th Nov 2015
3. The residents who smoke , will be informed of the emergency call bell location and use by Friday 20th Nov 2015
4. Resident smoking risk care plan will be updated to include the new emergency call bell as a control measure in accessing staff help.
5. The residents guide will be updated to include emergency call bell location 31 Dec 2015
6. The Fire safety plan will be updated and rolled out to staff ,to include the procedure for staff to follow in the event of a residents' clothing catching fire while in the smoking area-by 31 Dec 2015
7. The Health and Safety committee will discuss the new draft guidelines on fire precautions in Designated Centres
8. Non- clinical risk assessments will be updated to include the emergency call bell as control measure in the potential risk of a resident clothes catching fire while a resident is outside at the smoking area.

Proposed Timescale: 16/11/2015

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:

The date were not always recorded when a care plan had been reviewed or amended. This was not in line with professional nursing guidelines and also made it difficult to measure the effectiveness of an intervention.

2. 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. A clinical governance meeting will be held by Dec 4th to review the care plans in regard to dates not recorded on review or amendment
2. Care plans will be amended to ensure compliance with regulation 5(2) by 30 Dec 2015.
3. Staff nurse meeting will be held by 30th Dec 2016 to include discussion on professional nursing guidelines. Staff nurse meeting will also include direction on dating notes on care plans so as to ensure all interventions on care plans are easily measured

for effectiveness.

4. PIC's will continue to spot check care plans on a monthly basis, which will include the checking of dates and nurse signature.

Proposed Timescale: 30/12/2015

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 requirements of the National Standards for 2015.

The communal accommodations was not suitable in size.

Two of the double bedrooms did not provide sufficient space for the residents and did not meet requirements of the National Standards for 2015.

There was insufficient dining space.

3. 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:

In order to comply with the regulatory requirements of the National Standards, the following steps have been taken to date.

1. Application for planning permission was sought and granted 2015
2. A comprehensive Architectural plan has been written up and approved by directors for a new build. This new build will incorporate a new dining room, treatment room and bedrooms that will meet National standards.
3. All of the above have been forwarded to the Authority 2015.

To progress this plan, and in light of changes made to compliance dates of the National Standards, made on Wednesday 4th Nov 2015, the following steps will be taken to complete the action plan

1. Update loan application CV as requested by banking institution, with an accountant and financial advisor for Jan 2016.
2. Building work will go to tender February 2016
3. Bank application for loan May 2016
4. Building work to commence by July 2016

5. Building works to be completed Dec 2018.

Proposed Timescale: 31/12/2018

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Care plans could be further improved to guide more effective methods of communicating for residents with dementia and residents who were non-verbal.

4. Action Required:

Under Regulation 10(2) you are required to: Where a resident has specialist communication requirements record such requirements in the resident's care plan prepared under Regulation 5.

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

1. A clinical governance meeting will be held by 4th December 2015 to include a review of care plans in light of residents with dementia specific communication needs
2. Resident care plans will then be reviewed and updated to include guidelines for a more effective communication with residents by 31 Jan 2016.
3. The Thematic Inspection tool on dementia will be used as a resource for auditing communication needs- 31 Jan 2016.
4. A communication board will be erected in the communal space for resident s' use, to include common use pictures and needs of residents by Jan 2016
5. A Staff journal club will be created, to share articles of interest and education for staff by Jan 2016
6. Dementia specific training for PIC's will be sourced and agreed by March 2016
7. Dementia specific research will be undertaken by PIC's Aine Jones and Hazel Nangle by March 2016
8. Dementia specific training will commence by June 2016
9. All staff will have completed in- house training on dementia specific communication for residents by Sept 2016
10. Registered provider will source support from consultant in dementia, in regard to creating a building which incorporates dementia specific design and colour Dec 2016

Proposed Timescale: 31/01/2016