## Centre Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Centre name:</td>
<td>Clonskeagh Hospital</td>
</tr>
<tr>
<td>Centre ID:</td>
<td>0491</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Clonskeagh Road</td>
</tr>
<tr>
<td></td>
<td>Dublin 6</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 2680300</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:mary.nally@hse.ie">mary.nally@hse.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>□ Public</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Health Service Executive (HSE)</td>
</tr>
<tr>
<td>Person authorised to act on behalf of the provider:</td>
<td>John O’Donovan</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Mary Nally</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>28 November 2012</td>
</tr>
<tr>
<td>Time inspection took place:</td>
<td>Start: 08:20 hrs Completion: 17:45 hrs</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Deirdre Byrne</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Angela Ring</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>□ announced □ unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>85</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>14</td>
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About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by Regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of 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 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. 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 11 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.

<table>
<thead>
<tr>
<th>Outcome 1: Statement of Purpose</th>
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<tbody>
<tr>
<td>Outcome 2: Contract for the Provision of Services</td>
<td></td>
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<tr>
<td>Outcome 3: Suitable Person in Charge</td>
<td>X</td>
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<tr>
<td>Outcome 4: Records and documentation to be kept at a designated centres</td>
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<tr>
<td>Outcome 5: Absence of the person in charge</td>
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<td>Outcome 6: Safeguarding and Safety</td>
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<tr>
<td>Outcome 7: Health and Safety and Risk Management</td>
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<tr>
<td>Outcome 8: Medication Management</td>
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<tr>
<td>Outcome 9: Notification of Incidents</td>
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<tr>
<td>Outcome 10: Reviewing and improving the quality and safety of care</td>
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<tr>
<td>Outcome 11: Health and Social Care Needs</td>
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<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>X</td>
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<tr>
<td>Outcome 13: Complaints procedures</td>
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<tr>
<td>Outcome 14: End of Life Care</td>
<td>X</td>
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<tr>
<td>Outcome 15: Food and Nutrition</td>
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<tr>
<td>Outcome 16: Residents’ Rights, Dignity and Consultation</td>
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<tr>
<td>Outcome 17: Residents’ clothing and personal property and possessions</td>
<td>X</td>
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<tr>
<td>Outcome 18: Suitable Staffing</td>
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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 third inspection of Clonskeagh Hospital by the Health Information and Quality Authority (the Authority). The report for this and previous inspection reports can be found on the Authority’s website [www.hiqa.ie](http://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.*

Inspectors found residents’ were well cared for and had good access to medical services and a range of allied health professionals. Residents’ were involved in the organisation of the centre, and were regularly consulted with. A residents’ committee had been set up and met regularly. There were robust systems in place to protect and ensure residents were safe from harm and abuse. A suitably qualified nurse was deputising in the absence of the person in charge and inspectors found her to be familiar with the residents’ and their needs.

Inspectors found a number of issues required immediate improvements in order to meet the requirement of the Regulations in relation to management of risk in sluice room, fire service records and staff awareness of fire precautions. All were addressed either during the inspection or immediately afterwards.

The other main areas of non compliance were in relation to:
- residents’ health and social care needs
- medication management and procedures
- risk management in relation to meeting requirements of the Regulations
- fire safety training.

Inspectors also followed up on the actions required from the previous inspection. There were 10 actions, of which, one had been completed and nine had not been fully addressed. These areas not addressed were in relation to:
- not notifying wounds of grade two or more to the Authority within three working days
- staff personnel file not containing all information required by the Regulations
- communal rooms not large enough and lack of toilets for these areas
- residents/relatives not being involved in the development of their care plans.

As part of this inspection, inspectors also reviewed details of information of concern relating to wound management received by the Authority prior to the inspection. Inspectors found good systems in place for the management of wounds. However, improvements in care planning were found.

The 11 Outcomes covered on this inspection are discussed in the body of the report. All non-compliances and improvements required are outlined in the Action Plan at the end of the report.
Section 41(1)(c) of the Health Act 2007

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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 that the centre was managed by a suitably qualified and experienced nurse.

At the time of inspection the person in charge as detailed on the registration certificate was on leave and was being deputised in her absence by an assistant director of nursing. Inspectors found the assistant director of nursing was a qualified nurse with experience in care of the older person. She was familiar with the residents’ and their needs. She assessed their satisfaction and concerns with the service. She managed the centre with accountability and responsibility and was aware of the regulations and the requirements. There were regular staff meetings and daily handover meetings with night and day staff which she attended.

She had completed a diploma in Health Service Management a number of years before and continued her professional development having recently attended training in areas such as palliative care and a seminar of the dynamic care of the elderly.

The deputising assistant director of nursing was covered in her absence by a second assistant director of nursing for the centre, who was also present on the day of the inspection.
Outcome 5
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

References:
Regulation 37: Notification of periods when the Person in Charge is absent from a Designated Centre
Regulation 38: Notification of the procedures and arrangements for periods when the person in charge is absent from a Designated Centre
Standard 27: Operational Management

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

Inspection findings
Inspectors were satisfied that any absence of the person in charge for a period of time had been notified in writing to the Authority along with suitable alternative arrangements for their cover as required by the Regulations.

The person in charge was on leave for longer than 28 days and this had been notified to the Authority. As detailed in Outcome 3 above an assistant director of nursing was appointed as person in charge for the duration of the absence and is referred to as the person in charge throughout this report.

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.
Inspection findings

Inspectors were satisfied that measures were in place to protect residents from being harmed or suffer from abuse and that appropriate action was taken in the investigation into any allegation, disclosure or suspicion of abuse.

The inspectors found staff were knowledgeable of the procedures to follow in relation to elder abuse, and had received training in the prevention and detection of abuse. The person in charge was clear of her responsibilities in relation to the investigation and the reporting of an allegation or incident of abuse. There was a centre policy in place seen by inspectors. Residents told inspectors that they felt safe in the centre.

There were robust systems in place for the management of residents’ finances. Inspector saw a policy was in place to guide practice. All monies were held in a safe secure place. Small quantities were held at ward level with the remainder in a separate secure area. Only designated staff had access to residents’ finances at any time. Inspectors reviewed the finances for a number of residents and found them to tally with the balance recorded. There were detailed accounts kept of all deposits and withdrawals with the date, quantity and signature of the person carrying out the transaction.

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 found systems were in place to protect and promote residents health and safety. However, they were not robust enough in relation to risk assessment and fire safety.

A safety statement dated January 2012 was seen. It contained a schedule of risk assessments for hazards such as slip and trips, needle stick injury and fire. Inspectors found residents who smoked were risk assessed, however, there was inconsistent re-assessments carried out. Inspectors reviewed the risk management policy and found it did not meet the requirements of the Regulations. For example, there was no account of the precautions in place to control specified risk such as assault, violence and aggression and self harm. There were no arrangements in place for the identification, recording, investigation and learning from serious or untoward incidents involving residents. Inspectors reviewed an emergency plan for the centre. However, while it provided general information it was not centre specific and did not contain the alternative accommodation arrangements for residents in the event of an evacuation.

Inspectors were not satisfied that all staff were knowledgeable and clear of the fire safety arrangements in the centre. Inspectors spoke to staff and some were unsure and unclear of fire safety procedures. A review of training records found gaps in the provision of fire safety training for all staff on an annual basis. A large number of staff had no training since August 2011. This was discussed with the person in charge and assistant director of nursing. They showed inspectors details of training dates for February 2013. Inspectors found that fire drills took place during training. However, as there was a gap of a year between two training dates, staff were not aware of the procedures to follow in the event of a fire by means of regular fire drills. Inspectors requested that in the intervening period staff were to be provided with an immediate update of the fire evacuation procedures for the centre. Inspectors received information following the inspection confirming four dates for fire safety training to take place in December 2012.

There were documented checks of fire exits, extinguishers and so forth, generally carried out on a weekly basis. Fire exits were seen by inspectors to be unobstructed. However, there were concerns regarding the frequency of these checks. These were discussed with the assistant director of nursing. Information received following the inspection indicated daily checks of exits were to be immediately implemented. Fire orders were displayed throughout the centre and fire fighting equipment was in place. Fire fighting equipment was provided, however, inspectors could not review service history checks as they were unavailable at the time of the inspection. These were provided following the inspection and inspectors confirmed checks had been carried out annually. Fire alarm and emergency lighting servicing records were seen and inspectors clarified they took place on a quarterly basis.

There were good systems in place for the prevention and management of infections. A comprehensive policy was in place to guide practice. There was access to wash-hand basins in communal areas. There were hand gel dispensers available throughout and all wash-hand basins were provided with soap and paper towels.
Inspectors spoke to staff and found they were knowledgeable of infection control procedures.

There were procedures in place for management of waste. Clinical and non-clinical waste was segregated and stored in hardwearing containers. It was stored in a separate area on the grounds. There were waste management companies contracted to remove waste safely from the centre on a regular basis. There was separate storage for sharps, which were stored in small covered containers. Inspectors saw a number of these containers were kept in an unlocked sluice room. It was brought to the attention of the staff nurse in the unit and the person in charge who said it would be locked immediately.

There was secure access to the centre with security personnel based at the entrance of the building. A visitor's book was kept at reception and all visitors were requested by staff to sign in and out.

Inspectors reviewed training records for staff in the moving and handling of residents. All staff had up-to-date training with refresher training to be scheduled in February 2013. Inspectors observed staff following best practice in supporting residents who required assistance and the use of assistive equipment.

**Outcome 8**

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

**References:**

Regression 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 medication management procedures and policies were robust enough to ensure all residents were protected.

There was a medication policy reviewed by inspectors however it did not contain procedures for the prescribing, recording, disposal of medications, and the prescribing, administration and review of PRN (as required) medications.

Inspectors reviewed a sample of residents' prescription and administration sheets in one unit. There was no signature for prescribed medications on one residents' prescription sheet. Inspectors requested for the matter to be addressed immediately. The sheet was signed before the end of the inspection day and shown to inspectors who confirmed it had been addressed.
The prescriptions for crushed medication were not individually prescribed.

Inspectors found that reviews of medications were undertaken. However, there were inconsistencies in the recording of these three-monthly reviews.

Medications that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with the Misuse of Drugs (Safe Custody) Regulations, 1984. Nurses kept a register of MDAs. The stock balance was checked and signed by two nurses at the change of each shift. The inspector checked the balances and found them to be correct.

Medications that needed temperature controls were stored in a locked refrigerator. There were daily checks of the temperature using a thermometer and inspectors saw a record of these were maintained.

All nursing staff had undertaken medication management training in May 2012. Inspectors spoke to staff and found them to be knowledgeable of the procedures to follow in the administration of medication.

### 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:

Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any serious injury to a resident.

### Inspection findings

Inspectors were satisfied that a record of all incidents and accidents in the centre was kept. An accident incident book was held on each unit with details of the incident and the outcome recorded. At the time of inspection there was no incident or accident in the centre that required notification to the Chief Inspector.

While on the day of inspection no wounds of a grade two or more required notification to the Chief Inspector. However, the reporting of grade two wounds as a serious injury had not been done within three working days required by the Regulations.
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 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:

Set out each residents needs in an individual care plan developed and agreed with the resident.

Revise each residents care plan, after consultation with him/her.

Notify each resident of any review of his/her care plan.

Inspection findings

Inspectors found residents’ wellbeing and welfare was being maintained with a good standard of care provided and access to a range of services appropriate to their needs. However, improvements were required in relation to the use of restraint, the
assessments of residents’ needs, setting out needs in care plans and the involvement of residents in the process.

There was access to the services of two general practitioners (GPs) who regularly visited the centre. The residents had access to a range of allied health professionals. A physiotherapist and occupational therapist were both based in the centre, with additional services provided by dietetics, speech and language therapy (SALT), dental, optometry and old age psychiatry.

The centre was spread out over four levels and inspectors reviewed care plans for a sample of residents on each of these levels. Residents’ files were kept on a computerised system. While there was evidence of good care planning in the centre inspectors found inconsistencies in areas. There were inconsistent three monthly assessments of residents needs. In some cases assessments were not fully completed. Care plans were not developed for all residents needs. For example, weight loss, pressure sores, nutrition, falls and wounds. Care plans devised were not always person centred or in line with policy for example the management of behaviours that challenge. There was inconsistent involvement of residents in their care planning.

The management of restraint required improvement. There was a high use of restraint in the use of bedrails and lap belts in centre. Inspectors reviewed a number of files and found residents were not consistently assessed for the use of bedrails. There was no assessment for the use of lap belts and bedrails for one resident and no care plan in place. There was no documentation to clarify that restraint was used as a last resort and what alternatives had been considered.

Inspectors reviewed a sample of residents’ files and overall found good practices in the management of wound care. However, some improvements were required. There was no care plan in place for one resident’s wound. There was an incomplete assessment for risk of pressure sores in place for another resident. A number of residents assessed as being at risk of developing pressure sores had no care plan drawn up. Inspectors did find good practices in place when wound care documentation was in place. There were regular assessments, treatment plans and progress notes kept. There were medical notes on file clarifying residents’ appointments with specialists in outpatient services.

Inspectors reviewed a detailed policy in place for management of behaviours that challenge. However, it was not implemented in practice as residents were not being consistently assessed in line with the policy. A care plan reviewed described interventions that were not person centred or in line with the centres own policy.

Residents’ weights were taken monthly and where needed there were referrals to a dietician. There were assessments of residents’ nutrition. However, there was no care plan put in place for a resident who had weight loss in excess of five kilograms or more. This was not in accordance with the centres own policy. Inspectors also found that weights were recorded in the dietician’s notebook and not the residents own file.
The management of falls was guided by a policy. Resident were assessed on a three-monthly basis. However, one resident assessed as at risk of falling had no care plan to manage their needs. Falls were logged in the accident incident report form. There was analysis of falls on a quarterly basis, looking at the times and the locations of where falls took place.

Inspectors reviewed nursing notes in the residents' files, and not all entries were being signed and dated as per best practice.

Inspectors observed residents enjoying a range of group activities during the day. However, improvements were required in meeting the needs of residents’ who were highly dependent and cognitively impaired. The inspectors met the activities coordinator who worked in the centre four days a week. She outlined the different activities carried out in the centre which were mainly group activities such as bingo, films and music sessions, arts and crafts. There were regular visits from a dog therapy organisation every Wednesday and weekly hand massage sessions were provided. Inspectors found limited activities were available for residents who were highly dependent and cognitively impaired as activities took place in communal areas and were designed for residents who were comfortable in a group setting. The activity coordinator confirmed that activities only took place in the communal areas and therefore could not be accessed by highly dependent residents.

### 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:

- Provide suitable premises for the purpose of achieving the aims and objectives set out in the statement of purpose, and ensure the location of the premises is appropriate to the needs of residents.

- 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.

- Provide adequate communal accommodation for residents.

- Provide ventilation, heating and lighting suitable for residents in all parts of the designated centre which are used by residents.
Inspection findings

Inspectors found that the design and layout of the centre whilst new in its design, required improvements to meet the individual and collective needs of the residents.

There were four units contained on four levels in the centre. Each unit was similar in size design and layout, only slightly differing in one unit. The centre was maintained to a high standard both internally and externally. Throughout the centre it was maintained to a high degree of cleanliness and hygiene. There was evidence of regular cleaning taking place and inspectors met with two cleaners who were clear of the cleaning procedures to follow. Staff told inspectors that all maintenance issues would be reported to their line manager who would bring them to the attention of the person in charge. There was a maintenance department in the grounds of the centre who organised for repairs and works to be carried out.

The bedrooms in each unit were mostly single rooms. There were eight two-bedded rooms and three three-bedrooms which were used for respite care. The bedrooms were all generous in size. They each had an en suite shower, wash-hand basin and toilet. All beds had a call bell fitted, and inspectors found these were regularly serviced. All bedrooms had a wardrobe and locker for personal items. The residents added their own personal touches, with photos and paintings.

Inspectors found that while the communal space provided in the centre met the minimum requirements in accordance with the Authority's Standards, the physical layout and design of the building did not meet the needs of each resident. In each unit was a living and dining room. Inspectors found the dining and living rooms were small in size, and only accommodated a maximum of eight to ten residents at any one time. A separate communal area was provided on the ground floor where mostly activities took place and an open plan oratory located. However, more dependent residents were not facilitated to use these communal areas.

The dining room in the Whitebeam unit was located in what had previously been fitted out for a four-bedded room. The room contained wardrobes, lockers and was clinical in its design and layout. Very little change had been made to improve the layout of the room since the last report.

There had been some attempt in communal areas to add a homely atmosphere with flowers, pictures, and photos provided. However, these there was mostly a clinical atmosphere evident throughout these areas.

There was inadequate storage space, with residents’ en suites and the assistive toilet being used to store equipment.

There was no provision of a communal toilet for residents close to each of the dining and living areas on each level.

The smoking room was not adequately ventilated, with no mechanical ventilation for the removal of smoking fumes from the area.
There was a sluice room located on each level. They were fitted out with bed pan washer, sink and wash-hand basin.

All floors were accessible by two lifts. Inspectors did not review records of service history checks as these were unavailable on the day of inspection. The assistant director of nursing informed inspectors these records would be forwarded once they had access to them. These were forwarded to inspectors after the inspection who confirmed servicing of the lift had taken place.

There were separate staffs changing facilities provided along with staff toilets on each floor.

**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 14**

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

**References:**
Regulation 14: End of Life Care
Standard 16: End of Life Care

**Action(s) required from previous inspection:**

No actions were required from the previous inspection.

**Inspection findings**

Inspectors were satisfied that residents’ care at end of life met their physical, emotional and spiritual needs and respected their dignity and autonomy.

An end-of-life care policy was seen by inspectors. It had been updated in January 2012 and gave adequate guidance for staff in meeting residents’ needs at this stage in their life. Staff had recently attended training in end of life care to enhance their care of resident. There was a palliative care suite in the centre for residents and their family to allow for privacy and quiet.

The centre had links with a local hospice to provide additional support and care for residents at end of life.
Outcome 16
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.

References:
Regulation 10: Residents’ Rights, Dignity and Consultation
Regulation 11: Communication
Regulation 12: Visits
Standard 2: Consultation and Participation
Standard 4: Privacy and Dignity
Standard 5: Civil, Political, Religious Rights
Standard 17: Autonomy and Independence
Standard 18: Routines and Expectations
Standard 20: Social Contacts

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

Inspection findings
Inspectors were satisfied residents were consulted with and participate in the organisation of the centre, with systems in place to allow residents to communicate and enable them to exercise choice and control over their life.

An advocacy group had been set up in August 2012 and three meetings had been held since then. Five volunteers participated in running the group, consisting of past employees and a relative. Inspectors read the minutes of the last meeting and found issues raised were mostly food related. The inspector spoke to a number of residents who also raised their dissatisfaction with aspects of the food served. This was discussed with the person in charge. She was aware of the residents’ concerns, and there were ongoing efforts to address them both individually and collectively. For example, there were regular meetings of a catering circle. The group consisted of catering, SALT, dietician and nursing staff and they met regularly to discuss the catering and nutritional issues for the residents.

There were a number of outings organised from the centre with trips to the concert hall and the annual horse show arranged. Residents were facilitated to have trips locally if they wish, for example, for hairdressing. A hairdresser also visited the centre on a regular basis. There were regular music session in the afternoon and a recent party was held with music provided. Inspectors saw signs up for a Christmas party due to take place the following week.

There were newspapers provided daily to each unit and residents had a television set in their room. A portable telephone was available on every floor for phone calls to residents or for residents to make calls.
The residents’ political rights were facilitated. There were arrangements in place to ensure all residents had the option to vote. For the last referendum the local county council set up a polling booth in the centre to allow residents to vote.

Residents’ religious needs were being met. Residents came from Roman Catholic and Church of Ireland faiths. An oratory located in the centre and a visiting priest said mass regularly for residents who were Roman Catholic. The person in charge told inspectors residents’ said the rosary together after mass. A chaplain came to visit residents’ who were Church of Ireland.

**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**

Inspectors found that the action from the previous inspection had not been fully addressed and additional improvements were required in the documentation for volunteers.
Inspectors reviewed files for four members of staff and found that documentation was not completed for all. There was no evidence of Garda Síochána vetting for one member of staff, no references on file for one staff and no evidence of mental and physical fitness to work for all staff files reviewed. This matter had also been an action in the previous inspection report.

A number of volunteers work in the centre. Five are through an external company that organises volunteers. However, there was no evidence of a written agreement in place outlining their roles and responsibilities. For all other volunteers in the centre there was no evidence of Garda vetting or written agreement in place.

Inspectors reviewed training records for the centre. The assistant director of nursing explained to inspectors that every six months she reviewed the records and collated a list of staff that required mandatory training. Inspectors were shown details of training planned for February 2013, to include fire safety and manual handling amongst other training.

Inspectors found that a range of training had been provided for staff including palliative care, wound management and venepuncture. Most care assistants had undertaken Further Education and Training Awards Council (FETAC) Level 5. The assistant director of nursing told inspectors that a minority of care staff remained, who were due to attend FETAC Level 5 training.

There was a planned and actual roster for each of the four units. Inspectors found staffing levels in place during the day reflected the roster; there was the person in charge, assistant director of nursing, 17 nurses and six care assistants. While inspectors did not see inadequate staff on duty, a number of care assistants strongly reported to them that staff levels were inadequate. The inspectors brought this to the attention of the person in charge and asked that a review of staffing levels be undertaken.

Inspectors saw evidence in the nursing staff files of up to date registration with their professional body.
Closing the visit

At the close of the inspection visit a feedback meeting was held with the person in charge and the assistant director of nursing 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

30 November 2012
Provider’s response to inspection report *

<table>
<thead>
<tr>
<th>Centre Name:</th>
<th>Clonskeagh Community Nursing Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>0491</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>28 November 2012</td>
</tr>
<tr>
<td>Date of response:</td>
<td>19 December 2012</td>
</tr>
</tbody>
</table>

**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 7: Health and safety and risk management**

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

There was inconsistent assessment of residents’ who smoked to ensure regular review and updating of risk in this area.

The risk management policy did not meet the requirements of the Regulations for specified risk such as assault and self harm.

There risk management policy did not outline what arrangements were in place for the identification, recording and learning form serious or untoward incidents involving residents.

The emergency plan in place was not centre specific and did not outline what arrangements were in place for alternative accommodation in the event of an evacuation.

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

### Action required:

Put in place an emergency plan for responding to emergencies.

### 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:

<table>
<thead>
<tr>
<th>Provider’s response:</th>
<th>Timescale:</th>
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<tbody>
<tr>
<td>All Clinical Nurse Managers/named nurses have been directed to review all residents/patients who smoke in order to develop an individual risk management strategy around this activity and to record and review such practices стратегий in the residents/patients care plan. This assessment was completed in respect of all patients as at the 31/12/2013. Such practices will be kept under review.</td>
<td>Completed</td>
</tr>
<tr>
<td>The centres risk management policy is being reviewed and will be further developed to incorporate risk management strategies relative to assault and self harm. It will also reflect what arrangements are in place for the identification, recording and learning from serious or untoward incidents involving residents and/or staff.</td>
<td>Completed</td>
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</tbody>
</table>
Work had already commenced on the centre’s Emergency Management Plan (to Include Evacuation Plan) and this will be completed in early 2013.

| The provider is failing to comply with a regulatory requirement in the following respect: |
| Not all staff were fully aware of the fire safety procedures for the centre. |
| Training in fire safety and prevention had not been provided for all staff on an annual basis. |
| Fire drills were not carried out in the centre on a frequent basis with gaps of a year between drills. |
| There was no access to the servicing records of fire fighting equipment on the day of inspection. |

| Action required: |
| Provide suitable training for staff in fire prevention. |

| Action required: |
| Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life. |

| Action required: |
| Make adequate arrangements for detecting, containing and extinguishing fires; giving warnings of fires; the evacuation of all people in the designated centre and safe placement of residents; the maintenance of all fire equipment; reviewing fire precautions, and testing fire equipment, at suitable intervals. |

| Action required: |
| Maintain, in a safe and accessible place, a record of the number, type and maintenance record of fire-fighting equipment. |

| Reference: |
| Health Act, 2007 |
| Regulation 32: Fire Precautions and Records |
| Standard 26: Health and Safety |

Please state the actions you have taken or are planning to take with timescales:  | Timescale: |
Provider’s response:

Staff fire safety training reviews recommenced this week and further sessions booked for 2013. (See accompanying documents) copies of attendance records are maintained locally and available on request.

Risk Management Policy relative to Fire Safety obligations will be further strengthened to ensure that a robust Fire Safety regime is in place which is communicated to and reviewed with staff on a regular basis to ensure a controlled and managed response in the event of a fire.

A comprehensive fire safety maintenance and service programme is in place within the centre. Heretofore all service maintenance records were maintained off site by the appropriate maintenance office. The Registered Proprietor will ensure that all such records are available on-site effective immediately.

The Registered Provider will ensure that appropriate evacuation/fire drills are carried out regularly and that such occurrences are reviewed and appropriate learning is achieved. These events will be documented and evidence of same retained locally.

28 February 2013

Outcome 8: Medication management

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

The medication policy did not outline the procedures to follow for prescribing, recording of medications and the prescribing and administration of as required (PRN) medications.

Crushed medications were not individually prescribed for.

Medications were not consistently reviewed on a three monthly basis.

There was no procedure in place for the disposal of medications.

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:**

<table>
<thead>
<tr>
<th>Provider's response:</th>
<th>Timescale:</th>
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<tbody>
<tr>
<td>The Medical Officers have been provided with copy of the Authority’s report. They are aware that medications required to be crushed will be individually prescribed as such. The Clinical Nurse Managers are checking kardexes each month as to which three-monthly review is due and will bring to Medical officers attention, and record in Medical Officer’s ward diary. This process will be pro-actively managed going forward to ensure all appropriate reviews are carried out in line with the Regulations. The Medication Policy No. 7 will be further revised to include recommendations. Aspects of the requirement are already included see Section 6 page 5 of the current Medication Policy (attached) as all unused out of date medicines are returned to the pharmacy. Also attached please find copy of controlled drugs policy No. 8 Section 6, point no 6.3 (page 3) which reflects local practise. This will be included within Medication Policy No 7 to ensure appropriate cross reference with both policies.</td>
<td>31/01/2013</td>
</tr>
</tbody>
</table>

**Outcome 9: Notification of incidents**

**The person in charge is failing to comply with a regulatory requirement in the following respect:**

While on the day of inspection no wounds of a grade two or more required notification to the Chief Inspector. However, the reporting of grade two wounds as a serious injury had not been done within three working days required by the Regulations.
Action required:

Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any serious injury to a resident.

Reference:

Health Act, 2007
Regulation 36: Notification of Incidents
Standard 29: Management Systems
Standard 30: Quality Assurance and Continuous Improvement
Standard 32: Register and Residents’ Records

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

Provider’s response:

The person in charge accepts that there were deficiencies in reporting such matters in the past due to a misunderstanding as to the process and documentation to be used for such purposes. However, this situation has been reviewed and all such occurrences are reported as appropriate using the prescribed format/report as determined by the Authority.

Timescale:

In place and reviewed regularly

Theme: Effective care and support

Outcome 11: Health and social care needs

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

There was inconsistent assessment and in some instances incomplete assessments for residents in the centre.

The use of restraint was not consistently or comprehensively assessed, with no evidence of its use as a last resort or the alternatives considered.

Care plans were not consistently developed for all residents needs in relation to pressure sores, wounds, nutrition and falls.

Care plans were not consistently person centred or developed in line with policy such as behaviours that challenge.

There was inconsistent involvement of residents in their care planning.

Action required:

Set out each resident’s needs in an individual care plan developed and agreed with the resident.
**Action required:**

Keep each resident’s care plan under formal review as required by the resident’s changing needs or circumstances, and no less frequent than at three-monthly intervals.

**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:**

The Provider is committed to ensuring a comprehensive patient centred approach to care planning for all patients and is disappointed but accepting that deficiencies were highlighted in this regard. The Registered Provider/Person in Charge will ensure that a comprehensive review is undertaken in this regard and that appropriate further training is put in place for staff. The Person in Charge will be requesting the support of the HSE quality advisory service for additional training/advisory sessions relative to the continuous implementation and review of the DML document -awaiting confirmation of dates.

New Bedrails Risk Assessment document commenced all residents will be reviewed and updated. (copy attached).

Multidisciplinary Team have commended reviewing the residents on an ongoing basis.

Each ward has been alerted to inconsistencies and unfinished details in care plans and documentation. All clinical staff have been reminded of the importance of care planning being person centred in all aspects. The inclusion of resident and family an integral part of care planning as part of the care team.
Audits of the DML document have commenced and will be carried out and reviewed on an ongoing basis.

<table>
<thead>
<tr>
<th>The provider is failing to comply with a regulatory requirement in the following respect:</th>
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<tbody>
<tr>
<td>There were limited activities to meet the social care needs of residents with a cognitive impairment.</td>
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</table>

**Action required:**

Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.

**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:**

*Provider's response:*

While Peata and The Massage Therapist are available to all residents, a particular focus for these activities/therapies is residents who are cognitively impaired. Every effort is made to include as many residents as possible. The Activities Coordinator has had training in Sonas. In 2013 we have provisionally booked an additional Sonas training programme and plan to expand this to four members of staff which will afford us the opportunity to offer the service more regularly particularly to those patient who have a cognitive impairment.

<table>
<thead>
<tr>
<th>Outcome 12: Safe and suitable premises</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provider is failing to comply with a regulatory requirement in the following respect:</td>
</tr>
<tr>
<td>Parts of the building did not meet the requirement of the Regulations in relation to:</td>
</tr>
<tr>
<td>- the layout and design of the premises did not meet the needs of all residents</td>
</tr>
<tr>
<td>- the decor in some parts of the centre was not homely in its appearance</td>
</tr>
<tr>
<td>- there was no provision of independently located toilets close to the communal areas on all floors</td>
</tr>
<tr>
<td>- the smoking room was not ventilated to the external air by mechanical or natural means</td>
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<tr>
<td>- there was inadequate provision of storage space for assistive equipment.</td>
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<p>| Timescale: |
| 31/03/2013 |</p>
<table>
<thead>
<tr>
<th><strong>Action required:</strong></th>
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<tbody>
<tr>
<td>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.</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th><strong>Action required:</strong></th>
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<tbody>
<tr>
<td>Provide sufficient numbers of toilets and wash-basins which incorporate thermostatic control valves or other suitable anti-scalding protection, at appropriate places in the premises.</td>
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<thead>
<tr>
<th><strong>Action required:</strong></th>
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<tbody>
<tr>
<td>Provide ventilation, heating and lighting suitable for residents in all parts of the designated centre which are used by residents.</td>
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<thead>
<tr>
<th><strong>Action required:</strong></th>
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<tbody>
<tr>
<td>Ensure suitable provision for storage of equipment in the designated centre</td>
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<table>
<thead>
<tr>
<th><strong>Reference:</strong></th>
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<tbody>
<tr>
<td>Health Act, 2007</td>
<td></td>
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<tr>
<td>Regulation 19: Premises</td>
<td></td>
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<tr>
<td>Standard 25: Physical Environment</td>
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<tr>
<th><strong>Please state the actions you have taken or are planning to take with timescales:</strong></th>
<th><strong>Timescale:</strong></th>
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<tbody>
<tr>
<td>Provider's response:</td>
<td></td>
</tr>
<tr>
<td>The provider will review the internal configuration of the Unit in line with the recommendations contained within the report.</td>
<td>30/06/2013</td>
</tr>
<tr>
<td>The provider will review those areas where ventilation is deemed deficient (dedicated smoking area) and will address these and/or the practices which give rise to such concerns. The risk assessments for Residents who smoke have been completed and care plans reflect the management of such risks.</td>
<td>31/03/2013</td>
</tr>
<tr>
<td>Matters pertaining to physical storage space and storage practices will be reviewed and the endeavours already underway to enhance the facility and render it more &quot;homely&quot; will continue. The Person in Charge is committed to undertaking a survey with all existing and future anticipated Residents to assist in informing measures which can be undertaken to render the facility more &quot;homely&quot;</td>
<td>31/03/2013</td>
</tr>
</tbody>
</table>
### Theme: Workforce

#### Outcome 18: Suitable staffing

<table>
<thead>
<tr>
<th>The provider is failing to comply with a regulatory requirement in the following respect:</th>
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<tbody>
<tr>
<td>The documentation for all staff did not meet the requirements of Schedule 2 of the Regulations.</td>
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<table>
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<tr>
<th>Action required:</th>
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<tbody>
<tr>
<td>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.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Reference:</th>
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<tbody>
<tr>
<td>Health Act, 2007</td>
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<tr>
<td>Regulation 18: Recruitment</td>
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<tr>
<td>Standards 22: Recruitment</td>
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<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
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<tr>
<td>Timescale:</td>
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<tr>
<td>Provider’s response:</td>
</tr>
<tr>
<td>Staff are not employed within the Unit unless all appropriate recruitment and selection criteria are fully satisfied. This must include satisfactory references and appropriate current Garda vetting documentation. We endeavour to maintain details of this information locally and will review all staff records to ensure relevant personnel files are updated accordingly.</td>
</tr>
<tr>
<td>28/02/2013</td>
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<table>
<thead>
<tr>
<th>The person in charge is failing to comply with a regulatory requirement in the following respect:</th>
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<tbody>
<tr>
<td>There was no evidence of garda vetting and a written agreement outlining the roles and responsibilities for volunteers working in the centre.</td>
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</table>

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<tr>
<th>Action required:</th>
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<tbody>
<tr>
<td>Set out the roles and responsibilities of volunteers working in the designated centre in a written agreement between the designated centre and the individual.</td>
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</tbody>
</table>

<table>
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<tr>
<th>Action required:</th>
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</thead>
<tbody>
<tr>
<td>Ensure volunteers working in the designated centre are vetted appropriate to their role and level of involvement in the designated centre.</td>
</tr>
</tbody>
</table>
Reference:
Health Act, 2007
Regulation 34: Volunteers
Standard 22: Recruitment

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

Provider’s response:

We have forwarded Garda vetting forms to members of the Advocacy group and requested photo ID and appropriate character references. We will maintain appropriate documentation locally. We will ensure that all volunteers and support staff are advised on risk management practices associated with direct patient engagement and will ensure continuous review of such arrangements for the protection of all residents.

Timescale: 31/03/2013

Any comments the provider may wish to make¹:

Provider’s response:

The Provider welcomes the report of the Inspector and is committed to ensuring that the highest standard of care is afforded to our Residents. The Registered Provider is conscious that there are recurring environmental concerns arising from this and previous Inspections. In this regard the Registered Provider would welcome further discussion/engagement with the Inspectorate in order to determine appropriate parameters within which a strategy to address such matters can be developed.

Provider's name: John O'Donovan
Date: 7 January 2013

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