

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Community Nursing Unit Clonskeagh
Centre ID:	OSV-0000491
Centre address:	Clonskeagh Road, Dublin 6.
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Email address:	alice.harding@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	John O'Donovan
Lead inspector:	Deirdre Byrne
Support inspector(s):	Gearoid Harrahill
Type of inspection	Unannounced
Number of residents on the date of inspection:	89
Number of vacancies on the date of inspection:	1

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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 01 March 2016 08:00 To: 01 March 2016 19:30

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Compliant
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This inspection took place to assess ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards of Residential Care Settings for Older People in Ireland 2009.

As part of this inspection, inspectors met with residents, relatives and staff members. They observed practices and reviewed documentation such as care plans, accident logs, policies and procedures. Inspectors met the person in charge and assistant director of nursing (ADON) who were present during the inspection.

Inspector's found that there were very good governance arrangements in place. They observed staff who interacted with residents in a kind, dignified and respectful manner. The staff in turn were knowledgeable of the health care needs of residents along with their social care needs.

There were measures in place for the prevention of abuse and there were good

practices in the management of restrictive practices which were clearly documented and investigated. The staffing levels and skill mix were adequate to meet the assessed needs of residents, and robust recruitment arrangements were followed. Staff received mandatory as well as a wide range of training to meet the identified needs of the residents.

Some improvements were identified, and these are in relate to Outcomes on: health and social care needs, safeguarding and safety, medication management, and aspects of premises.

There were two actions from the previous inspection of October 2014. One was completed, and one relating to the premises was not fully addressed.

These and all other matters are outlined in the report and 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 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):

No actions were required from the previous inspection.

Findings:

Inspectors found there was a clearly defined management structure that outlined the lines of authority and accountability in the centre. The provider was in the process of completing the 2015 annual report. There were systems in place to review of the quality and safety of life of residents, with an area of improvement identified.

The centre is operated by the Health Service Executive (HSE). The provider had ensured there were adequate governance arrangements in place. The person in charge was now based full time in the centre. This had been formalised since the last inspection. She reported that this enhanced the day to day governance of the centre. She had delegated responsibility to unit level and clinical nurse managers (CNM2s) oversee the management at unit. Acting CNM1 staff also support management at unit level.

The person in charge reported directly to the provider regularly on a formal basis. A management committee met every 4 to 6 weeks. It included the persons in charge of other designated centres for older people in the regional area of the HSE. The person in charge who attended the meetings presented an update on the residents' needs, incidents, staffing and the day to day operation of the centre. The provider and the person were also in regular contact and met on an informal basis.

There were systems in place for the management of the centre. Inspectors read the minutes of clinical nurse manager meetings that took place every quarter. A range of topics were discussed in the minutes read. For example, incidents, staff issues, residents feedback and risk management. Within the centre, there were four units, and each were managed by a CNM2. The person in charge said this ensured local governance at unit level. There were unit meetings held by the CNMs at this level also. Minutes of which were read by inspectors.

There were multi-disciplinary meetings held at unit level relating to individualised residents and clinical risks. A sample of the minutes of these were read and it was evident that action and decisions were made in relation to the on-going review of the residents and clinical issues, risks and supervision of residents in the centre. For example, any reviews detailed at the multi-disciplinary meetings are incorporated into residents care plans.

There were systems in place to monitor the quality and safety of care, with some improvement required. Inspectors reviewed audits of care plans, falls, restrictive practices and complaints which had last been placed. There was a detailed analysis and action plan for the care plan and falls audits. There continued to be falls in the centre, and the provider had initiated a falls prevention programme as a result, she anticipated this would enhance falls practices in the centre. See Outcome 7 (risk management) for more details. The care plan audit was work in progress, as some issues were identified in relation as outlined in Outcome 11 (health care). There was no documented action plan for the use of restraint or complaints audit there it could not be ascertained what improvement was being brought about as a result of the audits. The person in charge said these were discussed at the quality, safety and risk committee and what action, if required was to be taken to address the findings.

A draft annual report for 2015 on the overall review of the safety and quality of care of residents was seen by inspectors. The person in charge said it would be brought to residents and their families for consultation once reviewed and approved by the provider.

Judgment:

Substantially Compliant

Outcome 04: Suitable Person in Charge

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Inspectors were satisfied that the centre was managed by a suitably qualified and experienced person with accountability and responsibility for the service.

The person in charge was a registered nurse who had the relevant length of experience required by the Regulations. She demonstrated adequate knowledge of the Regulations, and was aware of her requirements therein. The person in charge held regular meetings with staff, and the minutes of these meetings were read by inspectors and outlined a

range of issues discussed.

Inspectors found the person in charge was familiar with the residents' health and social care needs, and was observed interacting with residents during the inspection. The residents' in turn were very familiar with her and the ADONs.

The person in charge participated in ongoing professional development by attending seminar and courses on a range of topics. She had completed training in all mandatory areas.

There were satisfactory deputising arrangements with the person in charge supported by two ADONs. One was present during the inspection and demonstrated good knowledge of the residents' health and social care needs. The second ADON who was on leave came in briefly during the inspection to facilitate access to documents required to be reviewed.

Judgment:

Compliant

***Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

Theme:

Governance, Leadership and Management

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

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

Findings:

Inspectors found an area of improvement was identified in relation to residents records required as per Schedule 3 of the Regulations.

The completion of records of PRN medications administered without the maximum dosage in a 24 hour period prescribed.

Crushed medications were administered without being individually prescribed.

This is further discussed in findings in Outcome 9 (medication management) of the report.

Judgment:

Substantially 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):

No actions were required from the previous inspection.

Findings:

Inspectors found measures were place to protect residents and management the risk of abuse. However, the provision of elder abuse training for all staff and the use of restrictive practices required improvement.

There was an policy on the prevention of elder abuse which was dated 2014. In addition, there was a copy of the HSE Safeguarding Vulnerable Persons at Risk of Abuse, National Policy & Procedures of 2014. The person in charge had attended training in the new procedures, and was planning on rolling out the training to all staff in the centre. She was the nominated designated person to report incidents to in the centre. There had been two incidents of suspected abuse notified to the Authority since the last inspection. The person in charge had taken appropriate action and completed an investigation. Inspectors found she was very familiar with the procedures to be followed.

Inspectors spoke with staff who knew what action to take if they witnessed, suspected or had abuse disclosed to them. They also explained what they would do if they were concerned about a colleagues behaviour. However, some ancillary staff members spoken with were not so clear. In addition, ancillary staff working in the centre directly with residents had not received training in the prevention of abuse. Upon discussing this with the person in charge, inspectors were assured appropriate action would be taken immediately. The following day, the person in charge submitted training attendance sheets of the training she had provided to ancillary staff. These staff would be included in all elder abuse training going forward in the centre.

Records that were reviewed confirmed that staff had received training on recognising and responding to elder abuse, with gaps and areas of improvement identified above. The person in charge was a trainer in elder abuse training and facilitated the training in the centre.

The centre was managing the finances of some residents on their behalf. There were satisfactory safeguarding arrangements, which were reviewed with a senior staff

member. A clear system of recording all transactions was in operation. Residents and where required two staff signed the records. While there was a policy on the management of resident's property and valuables in place, it did not accurately reflect the practices in the centre. For example, resident's finances were held and managed by the main office and not at unit level.

The promotion of the National Policy "Towards a Restraint Free Environment" regarding bedrail usage required improvement. There was a policy on restrictive practices, which made reference to the National Policy. While it promoted a restraint free environment, this was still work in progress in the centre. For example, a recent bedrail audit read stated up to 54 residents used bedrails, and while 25 residents had requested them, 29 residents required bed rails in order to reduce the probability of a risk such as falls out of their bed. This was discussed with the person in charge at the feedback meeting who acknowledged that more reduction was required, and assured inspectors this would be reviewed and monitored through regular assessment and audits.

Inspectors found where residents required the use of bed rails risk assessments had been completed. A care plan was developed that confirmed when bed rails were in use. There was evidence that consent had been obtained or, consultation with families where required. The alternatives to bed rails had been considered for example low beds, and the risk assessment explained this in each case.

Inspectors reviewed incident reports in relation to resident's behaviour, and it was seen that a follow up of each incident was carried out with a risk assessment, and identification of any changes needed to reduce the possibility of it occurring again.

There was a visitor's book at reception, that all visitors, staff and work persons completed when on arrival and exit from the centre. A security officer was based at the reception full time.

Judgment:

Substantially 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):

No actions were required from the previous inspection.

Findings:

Inspectors found the provider had ensured there were arrangements were in place for the prevention and containment of fire; and to protect and promote the health and safety of residents, visitors and staff.

Inspectors reviewed an up to date safety statement for the service. The provider had policies on risk management that met the requirement of the Regulations. A risk register was maintained at centre and unit level. Risk assessment read were clear and detailed the controls in place to mitigate the likelihood of an adverse event, the risk rating, and the actions to protect residents from harm. Assessments included risk of assault through challenging behaviour, dangers of smoking, and unexplained absence.

There were systems in place to manage and document accidents and incidents. An incident log of accidents and events in the centre was reviewed by inspectors. The records included details of the incident, actions taken, and learning to prevent reoccurrence. Audits were carried on the number of incidents in the centre for example, falls and infections. The key points learned from trending the data were discussed and analysed by management and contributed towards continuous improvement to reduce these events for example, time, location of falls, witnessed or un-witnessed. It was hoped these figure would enhance staff knowledge of falls and how to mitigate and prevent their occurrence.

There were measures in place in to prevent the risk of injury to residents. A falls prevention programme was being piloted in one unit in the centre. A CNM who introduced the pilot described the programme to inspectors. It was based on evidence based research and involved subtle signage to highlight residents at a high risk of falls. The programme would involve the completion of regular checks and actions to reduce frequency and impact of falls in the future. The staff had received falls training and additional dates were scheduled for more staff to attend.

Staff also completed training in movement and handling and in the use of assistive equipment such as hoists. There were non slip safe floor surfaces. There were handrails provided on staircases and hallways and call bells, to support residents and to mitigate the risk of harm coming to residents in the centre. The centre was clean and well maintained.

There were systems in place to reduce the risk of infection. There were wash hand basins in communal areas, and a sufficient supply of hand gel dispensers, plus disposable gloves and aprons. Each unit had infection control guidelines to guide staff practice. The staff had also completed training in infection control measures.

There were adequate arrangements in place for the containment and prevention of the spread of fire. Suitable fire fighting equipment was provided for example, extinguishers, fire doors, emergency lighting and alarm equipment. Service records read confirmed the equipment was regularly serviced and in good working order. Evacuation procedures were prominently displayed in each unit. There was an emergency plan also provided at unit level.

The staff were trained in fire safety, which they attended on an annual basis. Inspectors found staff were knowledgeable of their role and the evacuation of residents in the event of fire. There were weekly fire drills, and records were maintained, which included any outcomes and observations to bring about improvement in efficiency of evacuation.

Each resident had a personal emergency evacuation plan (PEEP) which identified the level of assistance required by residents.

Judgment:

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):

No actions were required from the previous inspection.

Findings:

There were medication management policies and procedures in place to protect residents. However, the implementation of the policy required improvement.

Inspectors reviewed medication practices with a CNM on one unit, who was knowledgeable of the policies and familiar with best practice. Some residents' medication prescription and administration sheets were also reviewed. There were improvements identified by inspectors as follows:

- records for one resident indicated they were not administered medications at the prescribed time of 8am, and instead medications were administered at 11am. There was no documented rationale for administering the medications at the different time. This was discussed with the CNM who provided a legitimate reason. However, the matter required attention to ensure nurses carried out medication administration in accordance with professional guidelines.

- some residents who required medication on an as and when required (PRN) basis-the maximum dose to be given in 24 hours was not consistently recorded. See outcome 5 (documentation)

-a number of residents required their medication to be crushed. In some cases the medication was not individually prescribed as requiring crushing. See outcome 5.

-there was inconsistent documented evidence of a three monthly review of some residents' medications. Inspectors were told that the residents' prescription sheets were re-written regularly by the GP who would review medications. A multi-disciplinary team met regularly to review residents assessed needs.

All of the above matters were discussed with the nurse and the person in charge. A new administration/prescription record sheet was being introduced the week after the inspection. This document was shown to inspectors, and the person in charge

anticipated it would address the documentation deficits in the issues inspectors identified.

Where errors had occurred in the centre, records read confirmed an investigation was carried out. There was evidence of appropriate action taken, and shared learning with staff to bring about improvements in practice.

The pharmacy service had audited and reviewed medication practices. The person in charge described a new audit tool that was in the process of being rolled out in the centre.

Medications that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet at unit level. This was in keeping with professional guidelines. Nurses kept a register of MDAs. The stock balance was checked and signed by two nurses at the change of each shift. Inspectors checked a sample of balances and found them to be correct.

Medications were securely stored in each unit in a dedicated a treatment room inside a locked trolley. A secure fridge was also provided in each unit for medications that required specific temperature control. Inspectors noted that the temperatures were within acceptable limits at the time of inspection. There were appropriate procedures for the handling and disposal of unused and out-of-date medicines.

Judgment:

Non Compliant - Moderate

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):

No actions were required from the previous inspection.

Findings:

Residents' wellbeing and welfare was maintained to a good standard of nursing care, with good access to allied health services. There were good practices in the completion of care plans with a small area of improvement identified.

There was good access to services of two medical practitioners, who visited the centre five days a week. The residents' could also retain the services of their own GP if they

wished. Records showed that where medical treatment was needed it was provided. There was excellent access to internal allied health services such as occupational health, physiotherapy, dietician and speech and language therapy. In addition, residents were also seen by and referred to other services, for example, chiropody, optician or dentist. There was access to geriatrician and psychiatry of older age services in the area also.

Records showed that where there were known risks related to a residents care, they were set out in the care planning documentation on admission. Key nursing staff were allocated to residents and completed the clinical assessment and care plans for their identified needs, for example activities, communication, nutrition, daily living skills, mobility and pain management.

The care plans were seen to cover healthcare needs, with information about residents' social, emotional and spiritual needs included. A range of recognised assessment tools were used by nurses in identifying any changes or risks in areas such as nutrition, dependency, skin integrity and mobility. These were completed on a four monthly or more frequent basis. Some care plans required improvement as the plans did not consistently guide staff practice or reflect the good practices carried out. For example, nutrition, pressure sore prevention and end-of-life care. These matters were discussed with the person in charge who promptly addressed the matter and submitted the updated care plans to the Authority following the inspection.

Consultation with residents' or their families in their care plan reviews was evident. The person in charge said families and residents' were regularly updated on any changes made to their care plans but which was documented on residents files. This was evidenced directly on each residents care plans or in discussions recorded by staff on the residents' files.

Evidence was seen during the inspection that residents' were closely monitored, and where there was a change in the condition of the resident, action was taken quickly in response. Records showed that residents' had been seen by a GP, or in some cases went to hospital for further assessments. Where residents' had been admitted to hospital, transfer records were seen that detailed what the residents' needs were, and included any medication they were prescribed.

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

<p>Outstanding requirement(s) from previous inspection(s): Some action(s) required from the previous inspection were not satisfactorily implemented.</p> <p>Findings: This outcome was reviewed in the context of storage in the centre.</p> <p>Inspectors found that suitable storage was not available in the centre. During the inspection hoists, wheelchairs and recliner chairs were observed to be stored in some of the en-suite toilets, staff toilets, and communal bathrooms. The door of a staff toilet in one unit could not be closed due to the amount of equipment stored in the room. This was an action at all previous inspections and has not been fully addressed.</p>
<p>Judgment: Non Compliant - Moderate</p>

<p><i>Outcome 13: Complaints procedures</i> <i>The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.</i></p>
<p>Theme: Person-centred care and support</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: A complaints policy was in place that met the requirements of the Regulations, and outlined the procedures for recording and investigating written and verbal complaints.</p> <p>The complaints procedure was displayed prominently in the reception area of each unit for residents, staff and the visitors to see. The person in charge was the nominated complaints officer however, the displayed procedure required updating, as it identified a former member of management as the complaints officer. The procedures also outlined an appeals and independent review process for if the complaint cannot be resolved satisfactorily at centre level.</p> <p>Inspectors reviewed a logbook of complaints kept centrally and at unit level in the centre. The logbook contained detailed information on the nature of the complaint, the results of investigation, the actions and outcomes and the satisfaction status of the complainant. The documentation was accompanied by relevant correspondence between the provider and the complainant, and meeting minutes related to the investigation and resolution of the complaint.</p>

There was evidence that verbal complaints were recorded, investigated and prioritised similarly to written submissions.

Residents spoken to by inspectors expressed confidence that they could comfortably voice concerns and complain to staff and management.

Judgment:

Substantially Compliant

Outcome 18: Suitable Staffing

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

Theme:

Workforce

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

No actions were required from the previous inspection.

Findings:

Inspectors found there was an adequate staff number and skill mix to meet the assessed needs of the residents, the statement of purpose and the layout of the building.

There was a minimum of four nurses working in the centre at all times. To enhance the staff levels in the evening time, a "twilight" care staff was assigned to move between two units at night.

Inspectors reviewed a planned and actual staff rota for the centre which identified all grades of staff and the wards on which they were rostered.

Overall, staff were aware of the centres policies and procedures. The person in charge had introduced a programme of policy talks. Key operational policies would be read and discussed by staff in each unit every Sunday. A schedule of these talks was seen by inspectors.

The staff were observed being polite, respectful, patient and personable in their interactions with residents, and knowledgeable of the residents needs and interests.

Inspectors reviewed a sample of personnel files which contained the documents required in Schedule 2 of the regulations. There was documented evidence that all

nurses had up to date records of registrations for 2016 with An Bord Altranais agus Cnáimhseachais na hÉireann.

A number of agency staff were utilised- both care and nursing staff. There were service level agreements. These were seen by inspectors and confirmed that the staff were recruited in accordance with best practice and had completed mandatory training with the exception of ancillary staff who had not completed elder abuse.

There was documented evidence of mandatory training completed by staff in fire safety and the prevention of abuse. However, a small number of staff had not completed elder abuse training and is discussed in Outcome 7 (safeguarding and safety).

A programme of training in place. It was a two day session and all staff nursing were required to attend for two days, and care staff for one day. A number of staff had already attended the in-service training day the week before the inspection and two more dates were due in the coming weeks. The training included restraint, diabetes, wound care management, risk assessment, use of defibrillators, dementia care and movement. Other training completed by staff since the last inspection included: movement and handling, end-of-life care, cardio-pulmonary resuscitation, infection control and falls prevention.

Inspectors were informed the provider was in the process of constructing a database of staff training dates in order to more efficiently highlight deficits and those due to attend refresher training.

A supervision policy was in the process of being rolled out in the centre. Inspectors were informed nursing staff were being trained up to provided supervision for staff at each unit level.

There were a small number of volunteers scheduled to commence in the role. Inspectors reviewed files that included a description of their role, the supervision arrangements, and pending An Garda Síochána vetting.

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:

Deirdre Byrne
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:	Community Nursing Unit Clonskeagh
Centre ID:	OSV-0000491
Date of inspection:	01/03/2016
Date of response:	05/04/2016

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 02: Governance and Management

Theme:

Governance, Leadership and Management

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

There was inconsistent evidence of what improvements had been brought about from some audits carried out in the centre for example, restraint and complaints.

1. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively

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

monitored.

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

The PIC will initiate a systematic approach to the collation and measurement of outputs from Audit to ensure that evidence based approaches are adopted to address underlying "issues" which give rise to recurring theme's challenging the provision of safe and suitable care to Residents.

The PIC will target the data relative to the use of restraints and data arising.

The PIC will ensure that all such data is analysed and that such analysis informs service improvement measures which will be recorded and reviewed in line with further audit analysis to evaluate effectiveness or otherwise of these measures.

The PIC will embed this process in the formal Quality & Risk Governance framework within the Centre and will ensure this process is informed by all strands of care provision within the Centre.

Proposed Timescale: 30/06/2016

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

Crushed medications were administered without being individually prescribed.

PRN medications were administered without the maximum dose in a 24 hour period prescribed.

2. Action Required:

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

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

The PIC will ensure that all prescriptions and associated care plans for those Residents requiring crushed medications are reviewed and that the policy within the Centre is strictly adhered to in this regard.

The PIC will ensure that this requirement receives appropriate focus through the management team forum in the Centre and that GP's are specifically reminded of the Centre's obligation in this regard.

The PIC will further ensure that where PRN medications are prescribed that the maximum 24 hour recommended dose is strictly documented by the GP and medication

administration will be rigorously enforced by all nursing staff within the Centre.

New prescription sheets are being trialled at present to ensure prescribing and administration documentation meet the standards set down in the Regulations.

The PIC will review these necessities with the GP(s) and Pharmacist as well as the statutory obligation to carry out formal reviews on prescriptions and will reinforce the necessity for full compliance and observance in this regard with the Clinical Nurse Managers.

Proposed Timescale: 30/04/2016

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

The promotion of the National Policy "Towards a Restraint Free Environment" regarding bedrail usage required improvement.

3. Action Required:

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

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

The PIC will ensure continued promotion of a restraint free environment in accordance with the national policy as published by the Department of Health.

The PIC will initiate a systematic approach to the collation and measurement of outputs from Audit to ensure that evidence based approaches are adopted to address bed rail usage in accordance with the National Policy to ensure the provision of safe care and support to Residents.

The PIC will target the data relative to the use of restraints and data arising.

The PIC will ensure that all such data is analysed and that such analysis informs service improvement measures which will be recorded and reviewed in line with further audit analysis to evaluate effectiveness or otherwise of these measures.

Proposed Timescale: 30/06/2016

Theme:

Safe care and support

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

Ancillary staff working directly with residents had not been trained in the prevention of abuse.

4. Action Required:

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

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

The PIC has already ensured that all ancillary staff who had not previously undertaken Elder Abuse Training have now availed of same.

Proposed Timescale: 21/03/2016

Outcome 09: Medication Management

Theme:

Safe care and support

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

Medications were not consistently administered in accordance with residents prescriptions.

5. Action Required:

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

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

The PIC will ensure that the Medication Management Policy is strictly adhered to.

The PIC will ensure that all professional observations and or advices to nursing staff are clearly noted on the residents individual medication charts and that such observation (s) are reflected in the Care Plan for each resident where appropriate.

The PIC will ensure that all medicinal products are administered in accordance with the directions of the prescriber for the resident concerned and in accordance with any advice provided by that resident's pharmacist and/or regarding the appropriate use of the product.

Proposed Timescale: 30/04/2016

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:

Care plans did not consistently guide staff practice or reflect the good practices in place e.g.: end of life, pressure care and nutrition.

6. Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

The PIC will ensure that all Nurses and Nurse management maintain a sharp focus on ensuring that Care Plans reflect the health and social care needs of residents and that such plans inform and guide delivery of care.

The PIC will formulate a more effective audit tool which will identify where good practice is happening but is not reflected in the care plan. Any inconsistencies will be escalated to the Clinical Nurse Managers for review and will be the subject of individual performance management plans where necessary/appropriate.

The PIC will re-enforce the absolute necessity to record and detail all interventions and guidance both from healthcare professionals, the resident and or their family where appropriate.

Proposed Timescale: 30/06/2016

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:

Suitable storage is not provided in the centre.

7. 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:

The Provider Nominee will support the PIC in securing additional on-site storage for equipment. The Provider Nominee will also advise the Unit Manager to conduct an audit on equipping under the direction of the PIC which will assist in the appropriate usage

and storage of equipment used daily within the Centre and will identify all equipment which is surplus to daily requirements and therefore may be suitable for storage in close proximity to the Centre.

The above audit will also focus on potential areas within the care centre which may be suitable for designation as a storage location and the terms of reference will also include the procurement of additional on-site modular storage units which would be designated only for Clonskeagh Community Nursing Unit.

Proposed Timescale: 30/06/2016

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

The complaints policy was on display in the centre. However it contained outdated information on the designated complaints officer.

8. Action Required:

Under Regulation 34(1)(b) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

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

The PIC will ensure that the Complaints Policy is comprehensively reviewed to ensure only current information is contained therein. This review has already been undertaken and all "out of date" complaints publications have been removed from the Centre.

Proposed Timescale: 30/03/2016