<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Clonskeagh Community Nursing Unit</th>
</tr>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000491</td>
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<tr>
<td>Centre address:</td>
<td>Health Service Executive, Clonskeagh Road, Dublin 6.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 268 0300</td>
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<tr>
<td>Email address:</td>
<td></td>
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<tr>
<td>Type of centre:</td>
<td>The Health Service Executive</td>
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<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>John O'Donovan</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Helen Lindsey</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Ann Wallace</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>88</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>2</td>
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About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
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 Standards for Residential Care Settings for Older People in Ireland.

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

**The inspection took place over the following dates and times**

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
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<tr>
<td>28 February 2017 09:30</td>
<td>28 February 2017 17:00</td>
</tr>
<tr>
<td>01 March 2017 09:30</td>
<td>01 March 2017 17:00</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Compliant</td>
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<tr>
<td>Outcome 02: Governance and Management</td>
<td>Compliant</td>
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<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
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<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Compliant</td>
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<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Compliant</td>
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<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Compliant</td>
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<tr>
<td>Outcome 09: Medication Management</td>
<td>Compliant</td>
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<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Compliant</td>
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<td>Outcome 13: Complaints procedures</td>
<td>Compliant</td>
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<tr>
<td>Outcome 16: Residents' Rights, Dignity and Consultation</td>
<td>Compliant</td>
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<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Compliant</td>
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**Summary of findings from this inspection**

The inspection was carried out in response to the provider’s application to renew the certificate of registration.

Inspectors were satisfied that the residents received a good quality service. There was a high level of compliance with the regulations inspected from the Health Act 2007 (Care and welfare for Residents in Designated Centres for Older People) Regulations 2013.

During the inspection inspectors met with residents and some of their relatives, observed practice in the centre, and spoke with staff and the management team. They also reviewed a range of documentation including resident’s records, medication records, and the organisation’s policies and procedures.
Inspectors found that residents received a personalized service from a skilled staff team. There were high levels of nursing support available to meet their healthcare needs. There was good access to other medical professionals such as a general practitioner (GP), dietician, physiotherapy and speech and language therapy. Residents reported that they felt the service provided to them was of a good standard.

There were governance and management arrangement in place to ensure the service provided was in line with the regulations and standards. The management team provided support to staff working in the units, and regularly reviewed practice to ensure it met expected standards.

Residents were seen to be spending time as they chose in the centre. There was a range of activities available in the communal area of the centre, or in the different units in the centre depending on residents’ preferences.
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 Standards for Residential Care Settings for Older People in Ireland.

### Outcome 01: Statement of Purpose

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The statement of purpose set out the services and facilities in the designated centre and contained all the requirements of schedule 1 of the regulations. It was kept up to date and revised in September 2016.

**Judgment:**
Compliant

### Outcome 02: Governance and Management

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
There was a clear management structure in the centre, that was in line with that described in the statement of purpose. Inspectors found that the centre was resourced effectively and there were systems in place to ensure that a quality and safe service was provided to residents.
There were a wide range of systems in place to monitor the staff practice in the centre and ensure safe and effective care was provided. This included reviewing performance against key performance indicators, carrying out audits, and seeking feedback from residents and relatives. There was also a central oversight of the centres performance in relation to areas such as managing complaints. Audits were carried out in areas such as care planning, medication, meals and mealtimes, and modified diets. Staff spoken with were aware of the results of the audits and any areas they were responsible for delivering improvement. Nursing staff had implemented processes to support them to evaluate their own practice in relation to ensuring fully completed personal records for residents.

There were meetings held with the staff teams to keep them up to date on expected practice in the centre, and any updates to practice that needed to be incorporated. Staff said they found these meetings helpful.

The person in charge met with the provider nominee when required, and then provided feedback to quality, safety and risk meetings held on a quarterly basis which were chaired by the provider nominee. A review of the meeting minutes showed topics such as finances, staffing, transfer of residents, and admissions of residents were discussed.

The provider nominee was reported to visit the centre on a regular basis, and was kept informed of any issues in the centre by the person in charge.

The annual review for 2016 was reviewed by inspectors. It had been developed with feedback from residents and relatives. It was set out against the National Standards for Residential Care Settings for Older People in Ireland, and gave a review of the performance of the centre, and set out any areas where practice could be improved.

Judgment:
Compliant

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

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

Findings:
There was a full time person in charge of the designated centre who had the relevant skills, experience and qualifications required to carry on the role. They were familiar with the regulations and standards and had effective systems in place to make sure they were being met in the centre, and that residents' needs were met.
The person in charge was supported in their role by two assistant directors of nursing. Two clinical nurse managers II, take the lead for nights one working opposite the other.

**Judgment:**
Compliant

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**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:**
All of the documents required in schedule 2, 3 and 4 of the regulations were available for review and met the requirement of the regulations.

Inspectors observed that the policies and procedures were followed in the centre. Each unit had a full set of policies for staff to access as required. All policies had been reviewed on a regular basis, and had a review schedule attached to them. Audits were also carried out against some policies to ensure practice followed the directions, for example for medication management.

There was a policy on document retention, and records were seen to be stored safely but remained accessible when necessary.

There was insurance in place for the centre.

**Judgment:**
Compliant

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

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

### Findings:
Inspectors found there were measures in place to safeguard and protect residents from abuse. There were policies and procedures in place to cover the use of restrictive procedures and to support residents with responsive behaviour (challenging behavior).

The HSE national policy 'Safeguarding vulnerable persons at risk of abuse' was being implemented in the centre. It provided staff with clear procedures to follow in the event of an allegation of abuse being disclosed, suspected or witnessed. Managers responsible for implementing the guidance were clear of the procedures to follow and the actions required in relation to initial screening and further investigations that may be required. Inspectors spoke with other nursing staff and health care assistants who were all very clear about the action to take if they witnessed abuse or it was reported to them, and were able to describe the different types of abuse defined in the policy. All staff had completed up-to-date training in safeguarding of residents or were scheduled to complete it in the following month and records read confirmed this.

There was a detailed policy in place for managing behaviour that is challenging. It provided clear guidance to staff on the process to follow where residents had responsive behaviour (challenging behaviour). It included a protocol for assessing the residents' needs, and for putting a care plan in to place. Inspectors observed this policy was put in to practice in the centre, and that staff knew the residents needs well. Staff were seen to be supporting residents effectively to ensure they remained calm and settled by carrying out activities they enjoyed, such as walking.

There was also a policy on restraint use. It included definitions of restraint, and the process to be followed for any restrictive practice to be approved for use for individual residents. Where restrictions were in place there was a clear record of the decision making process including other less restrictive measures trailed. The approach was agreed with the resident and where appropriate a relative. There were audits of any agreed restrictions to ensure the procedures were followed, risk assessments were completed and resident continued to require the intervention. There was a commitment in the centre to follow the guidance 'Towards a Restraint Free Environment'.

Residents who spoke with inspectors said they felt safe in the centre. Feedback received in HIQA questionnaires also confirmed this. Comments were made such as 'there is always staff here to help me' and 'feel very safe'.

### Judgment:
Compliant
**Outcome 08: Health and Safety and Risk Management**

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

**Theme:**
Safe care and support

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

**Findings:**
Inspectors found that the health and safety of residents, visitors and staff was protected. Any risks within the centre were being identified and managed.

There was a detailed policy on risk management, which was seen to be put into practice with a detailed risk assessment document that covered areas of risk identified for the centre and the controls in place to mitigate the risk. For example, the evacuation plan, medication management, and potential for abuse. The register was regularly reviewed. Risk assessments were also in place for individual residents in relation to their particular needs, for example smoking and choking risk. Inspectors observed mitigating factors to reduce identified risks in place during the inspection, for example appropriate fire-fighting equipment in the smoking room.

The centre had a health and safety statement in place that had been updated and signed by a representative of the provider in 2017. It provided clear guidance for staff in relation to health and safety matters in the centre.

There was a policy in place around infection control and inspectors observed it was being put into practice by cleaning and catering staff, and staff delivering direct care to residents.

There was a fire safety policy in place in the centre. The procedure to follow in the event of a fire was displayed in visible places throughout the centre. All staff had received training in fire safety, and there was an ongoing program of drills taking place to ensure all staff felt confident to put the recently reviewed procedure into practice. Inspectors spoke to a number of staff and found that they were knowledgeable of their role in the event of a fire and they told the inspectors in a step by step fashion what would happen in the instance of the alarm sounding. They were familiar with the recent changes to the policy that included those getting residents ready for evacuation while waiting for a decision to be made if it was necessary. Residents spoken with said they felt confident staff knew what to do, and they had been involved in the drills so they knew what would happen.

Inspectors reviewed the service records of the fire-fighting equipment and it had been serviced within the last year. Records in place showed the fire alarm and emergency lighting had also been serviced on a quarterly basis. Records were seen that outlined and clearly logged checks which were to be performed by staff on a daily, weekly or
monthly basis, such as checking the escape routes are free of obstruction and combustible materials, the fire doors were operational and the exit signs were functioning. Fire exits throughout the centre were well signposted and were unobstructed. Fire equipment was seen to be available in each of the areas of the centre.

**Judgment:**
Compliant

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**Outcome 09: Medication Management**

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

**Theme:**
Safe care and support

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

**Findings:**
Staff were seen to follow medication management policies and procedures in place to protect residents.

There was a medication policy that was accessible to staff at all times. It gave clear guidance to nursing staff on areas such as ordering, administration, disposal of un-used and out of date medications and medication errors.

Samples of resident's medication records were reviewed. Resident's medication prescription sheets were clear with medication clearly identified with the route, dose and time for administration. The administration sheet was signed by the member of staff, and there was a signature sheet for ease of identification of written entries. There was space to record when a medication was refused on the administration sheet. Drugs being crushed were signed by the general practitioner (GP) as suitable for crushing, and liquid alternatives had been sourced where available. As required (PRN) medication had the maximum dose in 24hrs clearly recorded.

Inspectors observed staff on two units and found they were following relevant professional guidelines.

Medicines were being stored safely in a locked room and in the medication trolleys used by nurses during medication administration rounds. There was also a locked medication fridge in each unit.

Nurses kept a register of controlled drugs, and storage was seen to be secure. They were checked by two nurses at the change of each shift. The inspector checked a selection of the medication balances and found them to be correct.
There was a process for assessing whether a resident was able to manage their own medications that included a risk assessment.

There was regular monitoring of practice in relation to medication management, and staff were found to be meeting the expected standards. Audits also identified good practice. Where improvements were identified they were seen to have been put in practice, for example improvements in sign off and administration of crushed medication.

The general practitioner and pharmacist reviewed medication on a four monthly basis, or sooner as required.

**Judgment:**
Compliant

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**Outcome 11: Health and Social Care Needs**

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

**Theme:**
Effective care and support

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

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

**Findings:**

Resident's wellbeing and welfare was being maintained by a staff team who were knowledgeable of the needs of residents. One area of improvement was required in relation to resident's care plans.

The process for admission followed the centre's procedure that included completing a pre-admission assessment. A more detailed assessment was then carried out when the resident was admitted for long term care, or respite care.

All resident's had care plans in place that were developed on admission, and this was added to following any review of the resident needs. Examples were seen of good practice where plans were developed for areas where resident's needed care or support, and they provided clear instruction for the staff supporting the resident. However some examples were seen where it was not clear from the care plan what the residents current needs were, and how they were to be met. One example related to continence, another to wound care, and another to the management of diabetes These were discussed with the nurse on duty at the time of the inspection, and steps were being
taken to make the improvements before inspectors left the centre.

A document in place for residents called a 'key to me' set out resident's likes and dislikes, and staff were seen to be familiar with the content of these documents as they were knowledgeable about individuals preferences.

Hand written care plans were being typed up to ensure residents could read and understand them if they wished to review them. Records showed there were regular meetings with the resident and where appropriate their family in order to review their care. Residents had signed their care plans where they were able.

There was regular contact with a general practitioner (GP) service, who visited the centre on a regular basis. Residents could identify their own GP if it was their choice. Medical notes showed resident needs were assessed and reviewed on a regular basis by the nursing staff with the GP, and referrals were made to other medical professionals were required.

Records showed that residents had timely access to allied health professionals for example physiotherapy, speech and language therapy and a dietician. Where recommendations were made for a resident they were implemented. Inspectors spoke with the dietician during the inspection who explained how they were able to respond quickly to any referral to review a residents diet, and were available to give advice to the care and catering staff where required.

Where residents were temporarily absent from the centre, records showed that relevant information was sent with them. Also when residents returned to the centre, for example from hospital, there was a clear summary of the residents needs and guidance on any interventions needed.

Judgment:
Substantially Compliant

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

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

Findings:
The design and layout of the building were in line with the statement of purpose. The centre was purpose built as a nursing home. It was set out in five units, four of which were used for resident accommodation, and the other for a range of activities and events.

There was an elevator for travelling between floors and all areas were suitably spacious for those with reduced mobility or in wheelchairs to move around freely. Handrails lined all corridors, and safe floor coverings were used throughout the building.

The centre was well lit and heated and there were ongoing works to improve ventilation to manage the temperatures during warmer weather. The centre was found to be clean and in a good state of repair internally and externally.

All bedrooms had en-suite facilities with accessible toilets and showers. Bedrooms were furnished with a bed, wardrobe, chair and lockable bedside cabinet, and were personalised to the residents’ preference, with photographs and artwork, and had adequate storage space for clothing and belongings. In double and triple rooms there was screening to ensure residents privacy and adequate space for staff providing care and support. The triple rooms were only used for resident's staying in the centre on a respite basis.

There was a functioning call bell by each bed, and in the communal areas of the centre. This set off an alarm in the unit that could be heard by staff in order that they could respond promptly.

Each unit had seating areas. There were used by residents for relaxing, seeing visitor and some chose to dine in them. There were also dinning rooms in each unit.

There was access to a large area in a separate unit in the centre. Religious services, entertainment and activities were offered in this space. There was also direct access to an enclosed garden area that residents could access independently.

Catering was done on-site and meals were brought to kitchenettes on each unit to be served.

There was an adequate amount of assistive equipment for the number and needs of residents in the centre, such as wheelchairs and air mattresses, and a log was available including service records and certificates that these were kept in working order.

Storage of equipment had improved since the last inspection with a nearby building being used to store large items, and equipment not required on a daily basis.

Judgment:
Compliant

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

Theme:
Person-centred care and support

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

Findings:
Inspectors found that where concerns or complaints were raised they were listened to and acted on.

The policy for the management of complaints clearly described the steps to be taken by staff who received a complaint, and those responsible for following them up. There was a nominated person to manage complaints and a separate nominated role to oversee the management of complaints. A suitable appeals process was also detailed in the policy.

There was a complaints procedure on display throughout the centre which outlined how residents or relatives could make a complaint. There were posters on walls, leaflets and boxes to post feedback by each unit in the centre. There was also an information folder for each resident in the centre that contained information on raising concerns and complaints. Those residents and relatives spoken with said they new who to speak to if they wanted to make a complaint. In the questionnaires returned to HIQA, residents mostly said they would tell family if they had concerns, followed by nursing staff. Relatives said they would report concerns to the nurse manager of the relevant unit in the centre.

The inspectors reviewed the complaint records that were available in each unit and found that both written and verbal complaints were being recorded. The records included detail of the complaint, the actions taken and the satisfaction of the complainant. The person in charge submitted reports on any complaints received in the centre to a central unit who reviewed the process followed against the policy.

There was no evidence to suggest that anyone was adversely affected from making a complaint

Judgment:
Compliant

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

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

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

**Findings:**
Residents were consulted on the running of the centre and there were opportunities for them to provide feedback on the service they received in the centre.

A range of meetings were held with the residents. There were residents meetings, advocacy meeting chaired by an external advocate, and menu meetings. Each had an agenda around issues that impacted on the residents. There were also next of kin and family meetings. There were minutes for each meeting with clear actions set out, and the person responsible for putting them in to action. Suggestions for a wider variety of meals was seen to have been put in to place by the chef. Steps had also been taken to ensure residents received a piping hot meal, and resident confirmed this was better now. There was also a request for milk to be put on tables in jugs, and this was observed during the inspection.

Resident satisfaction questionnaires had been circulated in the units. The findings were generally positive, and where improvements had been suggested action had been taken by the person in charge. For example an information pack had been put together for each resident giving up to date information on all areas in the centre, including how to raise any concerns.

Residents had access to TV, radio, newspapers and telephones. There were also film screenings put on in the main communal area.

There was a wide range of activities and entertainment seen to be available in the centre. There were two members of staff carrying out the role of activity coordinator. They carried out activities in the communal area including arts and crafts, quizzes and games, and musical activities. Residents were heard stating they enjoyed the activities they had attended. It was reported that activities were put on in the garden when the weather permitted.

There were also activities provided in the units for those residents who did not want to go to the main area. It included Sonas, musical exercise, arts and crafts and reminiscence groups. Where residents required support with activities such as walking to maintain mobility this was incorporated in to the plan for activities in the unit to ensure each resident was supported to be engaged in activities they were interested in and of benefit to them.

Where residents wanted to practice their religion this was supported with mass read in the centre weekly. It was also possible to watch mass on other days in the TV, with live streaming from a local church.
Inspectors spoke with residents who confirmed they were supported to make choices about how they live their day to day life. For example when to get up, what to have to eat and drink at meal times, where to spend time in the centre, and whether to get involved in activities taking place in the centre. Some residents said they preferred to spend time in their rooms and they were fully supported in this, but kept up to date on the range of activity available if they became interested.

There were places for residents to meet their relatives in private and carry out other activities in private. Relatives spoken with during the inspection said they were made very welcome in the centre, and found the staff to be very supportive. This was also confirmed in the questionnaires returned to HIQA from relatives.

There was access to advocacy in the centre and contact details were provided in the residents information guide.

Residents were supported to vote in elections if they chose.

**Judgment:**
Compliant

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### 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 number of staff with the skills and experience to meet the needs of the residents and to suit the layout of the building.

Each unit had a nursing team allocated with a CNM2 as lead for the service provided in that area of the centre. They were supported by nursing staff and healthcare assistants. There was oversight provided daily from the assistant directors of nursing and the person in charge. The shift patterns had been designed to ensure residents needs were met through the day and night.
Where agency staff were used, there was an attempt to get the same people to ensure consistency for residents. Inspectors observed the induction carried out for staff to familiarize them with the way the centre operated. There was ongoing recruitment to appoint to vacant posts with the intention to reduce the use of agency staff when new staff takes up post.

Residents spoken with were positive about the staff team, and said they were very approachable. They were seen to interact with the residents in a positive way with respect for residents’ preferences.

There were arrangements in place for annual appraisals of all staff. The person in charge appraised the management team, and then the lead nurse in each unit carried out appraisals of staff on their team. There was ongoing oversight of nursing practice, and sharing of information on up to date nursing practice arranged through team meetings.

Staffing rosters were available in the planned format, and the actual roster that was in place on each day. These were reviewed and matched the staff present in the centre.

A sample of personnel files for staff and these were found to contain all information and documentation required under schedule 2 of the regulations. Garda vetting confirmation was present for all members of staff and for regular visitors who facilitated activities in the centre. Records also included confirmation of registration with An Bord Altranais for all nurses active in the centre. There were service level agreements in place to ensure agency staff had relevant qualifications, training and Garda vetting.

There were clear records of the training completed by the staff team, that included fire safety, and the prevention of abuse. There was a wide range of training opportunities for staff including attendance on courses for dementia, forever autumn fall prevention, speech therapy, medication management and wound care. Staff members involved in management had all undertaken an introduction to management training course. There was a training plan for 2017 that was developed to meet the training needs of the staff team, with the purpose of supporting staff to maintaining existing skills and develop new ones. This was seen to have a positive outcome for residents, as staff were well trained and experienced in meeting their needs.

**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:*

Helen Lindsey  
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 report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Clonskeagh Community Nursing Unit</th>
</tr>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000491</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>28/02/2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>30/03/2017</td>
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</tbody>
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Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

Outcome 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:
There were some examples of care plans seen where it was not clear from the care plan what the residents current needs were, and how they were to be met.

1. Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
The Person in Charge will ensure that the current and future anticipated clinical and non-clinical needs/wishes of the resident’s are documented in their care plans and that specific action and defined timeframes are demonstrated in this regard.

1. The above action will be supported and implemented through dedicated care planning workshops. Clinical Nurse Managers will facilitate these workshops with all staff nurses under the direction of the PIC. Planned date for completion 30/06/2017.

2. Care planning support will be provided for staff nurses in a coaching opportunity hosted once per week. This will be facilitated by the Assistant Director of Nursing. Planned date for completion: 30/09/2017.

3. The PIC will also investigate the potential benefits of an electronic care planning package. The person in Charge and the Provider Nominee will complete this evaluation. Planned date for completion 31/12/2017

Proposed Timescale: As above all to be completed 31/12/2017

Proposed Timescale: 31/12/2017