Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Clonskeagh Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Clonskeagh Road, Dublin 6
Type of inspection:	Unannounced
Date of inspection:	11 May 2022
Centre ID:	OSV-0000491
Fieldwork ID:	MON-0036822

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Clonskeagh CNU is located in South Dublin and is run by the Health Service Executive. It was purpose built and provides 81 long-term care and 9 spaces for respite care. There is also a 16 person day care service run on the same premises. The staff team includes nurses and healthcare assistants at all times, and access to a range of allied professionals such as physiotherapy.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	80

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 11 May 2022	09:25hrs to 17:10hrs	Kathryn Hanly	Lead
Wednesday 11 May 2022	09:25hrs to 17:10hrs	Deirdre O'Hara	Support

What residents told us and what inspectors observed

From what residents told us and from what inspectors observed, residents were happy with the care they received within the centre. Inspectors observed many positive interactions between staff and residents. Overall, inspectors observed a relaxed environment in the centre throughout the inspection day. Staff were seen to treat residents with dignity and respect and residents were seen to respond well to this.

When inspectors and visitors arrived at the centre they were guided through infection prevention and control measures necessary on entering the designated centre. These processes were comprehensive and included a signing-in process, hand hygiene, the wearing of face masks, and checking for signs of COVID-19.

Clonskeagh Community Nursing Unit was located over five floors with access between floors by means of lifts or stair cases. There was a range of communal rooms and hallways that were bright and decorated in a homely fashion. The premises was seen to be generally clean and well maintained, however in Maple unit, the walls along the corridor and panelling and desk edging were damaged. This could impact on effective cleaning processes.

Generally there was good practice when staff were putting on and taking off personal protective equipment (PPE). However, practices in the centre did not always align with safe infection prevention and control standards. For example, staff did not always wear PPE in the correct manner. A small number of staff were seen to wear surgical masks when giving personal care to residents and one staff member was seen to wear a surgical mask under their nose. This may result in onward transmission of an airborne or droplet infection for residents or staff. Two staff were observed to be wearing hand or wrist jewellery which meant that hand hygiene may not be effective. In one clinical room, four sharps bins did not have the temporary closure mechanism engaged when they were not in use.

Visitors who spoke with inspectors said that they were happy with the cleanliness of the centre and that staff were very supportive in ensuring that they cleaned their hands and wore a face mask before entering the centre. Another visitor said that they come to visit when they liked, as there was no restriction except for meal times. They said that they were kept updated regularly on changes regarding COVID-19 and any restrictions and staff make sure that they are well before they enter the centre. One visitor commented that the "joy had gone out of the centre since COVID" and they were not happy with how visiting was managed. They said that they heard music for the first time since the start of pandemic on the day of this inspection. The return of this music was welcomed by residents and visitors.

Residents and visitors who spoke with inspectors said that they were delighted to be able to enjoy going out for meals, celebrating family occasions such as weddings and birthdays without having to restrict their movements when they returned to the

centre. Mass was still celebrated in the centre and took place on individual units. Some visitors said that the gardens were not maintained well, while others said they enjoyed the going for walks on the grounds. Inspectors saw that there were overgrown plants and some beds were not maintained in surrounding garden/courtyard areas. Inspectors were shown records of resident's participation and involvement in celebrating world hand hygiene day on 5 May 2022.

Family members mentioned that if their family member's condition changed, they were promptly seen by the Medical Officer or they could contact them directly.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

This was an un-announced inspection focused specifically on Regulation 27: Infection Control. There was insufficient oversight and monitoring of infection prevention and control systems. Details of findings are set out under Regulation 27.

This centre was managed and owned by the Health Service Executive. The infection control governance structures were evolving and the infection prevention and control committee was part of the quality and safety committee, which met on a bi-monthly basis. The infection control program was developing to include monitoring of antimicrobial use. While monthly monitoring of health care associated infections and antimicrobial use were completed there were gaps in information with regard to colonisation noted. This could result in delayed identification of any onward transmission of a health care associated infection.

There was a failure in communication system of infection control risks relating to legionella in the centre, in order that findings could be adequately addressed. For example, there was no evidence of communication from the maintenance team to the person in charge with regard to findings from abnormal legionella testing results. This could result in appropriate measures not being put in place to manage such a risk or delayed identification of a possible legionella infection. Inspectors requested records of actions taken as a result of these findings to be forwarded to the Chief Inspector on the day after this inspection. These were not forwarded.

Regular infection control audits were carried out. However, these audits were not tracked and trended to monitor progress. There were no records of actions required or improvements that had been completed as a result of audits undertaken.

The person in charge was the lead for infection control in the centre. A registered nurse was the nominated infection control link practitioner. They were given two days of protected time each week to support infection control practice and undertake auditing. Records showed the work completed by this person each week,

for example audits undertaken. This person was supported by the Community Health Organisation (CHO) infection control lead and infection control specialists from another CHO. In addition, some staff were trained as hand hygiene champions to promote and support good hand hygiene practice.

Infection prevention and control training was provided though a combined approach using e-learning and face to face training. The system to monitor training was not sufficiently robust to ensure that all staff had received the appropriate training relative to their role. While there was sufficient staff to deliver direct care, there were two vacancies at assistant director of nursing level. These roles were in the process of being filled.

The provider was carrying out staff serial testing fortnightly to allow for early identification of COVID-19 infection. On the day of inspection, suitable and sufficient staffing and skill mix were found to be in place to provide care for any resident restricting their movement in the centre and support cleaning.

A recent outbreak of COVID-19 had closed on 28 April 2022. Prompt identification of possible signs of COVID-19 allowed the provider to put in measures to prevent onward transmission of the virus. Inspectors were informed that the provider intended to carry out a review to identify areas of good practice and areas for further development or improvement.

An in-depth review was completed following the last substantial outbreak and learnings were seen to be implemented into practice. For example, a proactive approach to testing for COVID-19 and managing units in the centre separately to prevent onward transmission. Comprehensive cleaning check lists with guidance for cleaning staff to maintain standards expected was in use. In addition, the services of the principal psychologist was available to staff to support them, if needed.

Quality and safety

Overall residents' wellbeing and welfare was maintained by a good standard care and support. While many residents were content living in the centre and said they felt safe, improvement was required in infection control to ensure that standards expected were met. For example monitoring of training and audits, communication with regard to visiting and management of Legionella and appropriate cleaning processes.

It was seen by inspectors that visiting was managed in line with National guidance however, there was some ambiguity noted from a senior nurse with regard to their knowledge of the centres visiting policy. A small number of visitors said that they were dissatisfied with regard to how visiting was managed, they said that visiting was still being scheduled and was restricted to a nominated support person. Conversely other visitors said they were satisfied with the visiting arrangements.

Residents and staff were monitored for signs of infection twice a day to assist in the early detection and so that measures could be put in place to prevent the spread of infection.

While monthly monitoring of health care associated infections and antimicrobial use were completed there were gaps in information with regard to colonisation noted. This could result in delayed identification of any onward transmission of a health care associated infection.

While safety engineered sharp management devices were used not all sharps bins had the temporary closure mechanism engaged when they were not in use. Hand hygiene facilities were provided in line with best practice and national guidelines. There were ample hand wash sinks dedicated for staff use in the centre. The available hand hygiene sinks complied with current recommended specifications for clinical hand hygiene sinks.

The physical environment was generally well-maintained and ventilated. Corridors are free of clutter, bright and clean. However, there were gaps in practice important to good infection prevention and control which required action and is discussed in more detail under Regulation 27: Infection Control.

Regulation 27: Infection control

The registered provider had not ensured effective governance arrangements were in place to ensure the sustainable delivery of safe and effective infection prevention and control and antimicrobial stewardship. This was evidenced by;

- Surveillance of antibiotic use, infections and colonisation was not used to inform antimicrobial stewardship measures. Measures taken would improve the quality and safety of care.
- Regular environmental hygiene audits were carried out. However infection prevention and control audits were not tracked and trended to monitor progress. There were no records of actions or improvements that had been implemented as a result of audits undertaken. Furthermore, disparities between the consistently high levels of compliance achieved in local infection control audits and the observations on the day of the inspection indicated that there were insufficient local assurance mechanisms in place to ensure compliance with infection prevention and control measures.
- Local infection prevention and control guidelines did not give sufficient detail on the care of residents colonised with Vancomycin-resistant Enterococci (VRE). A care plan for a resident with VRE reviewed did not provide appropriate detail to guide safe and effective infection control practices. It did not adequately describe the routes of transmission to enable staff to take appropriate precautions. The guidelines also required review to guide staff how to clean and store nebulizer masks and chambers.
- Routine monitoring for legionella in hot and cold water systems had identified

high counts of legionella bacteria in a small number of samples. Remedial actions had been taken, however, re-sampling was not undertaken. The person in charge and the unit manager had not been informed of the results to ensure that the appropriate action was taken if a resident became symptomatic. This meant that there was a potential of legionella infection for residents.

- An up to date infection prevention and control training matrix was not maintained. Consequently the provider did not have oversight of areas of infection prevention and control training that were outstanding and in the absence of up to date training could not be assured that the staff had the required knowledge. This inspection found that refresher training was required with regard to the management of blood and body fluid spills. Staff spoken to gave differing processes in how they would deal with spills. For example they said they would spray chlorine based solution on urine and would use the incorrect dilution of chlorinating solution on blood spills to effectively decontaminate an area.

There were gaps seen in some practices to ensure effective infection prevention and control is part of the routine delivery of care to protect people from preventable health care-associated infections. This was evidenced by:

- Inspectors observed that a small number of staff did not routinely wear respirator masks for all resident care activity as recommended in HPSC guidelines.
- Inspectors were informed by three staff members that the contents of commodes/ bedpans were manually decanted into the sluice and manually cleaned prior to being placed in the bedpan washer for decontamination. This may result in an increased risk of environmental contamination and cross infection.
- Inspectors observed that the detergent in one bedpan washer had expired a number of years previously. This may impact its efficacy.
- Routine decontamination of the care environment was performed using a combined detergent and disinfectant solution at a dilution of 1,000 parts per million when there was no indication for its use.
- Inspectors observed domestic waste inappropriately disposed of in the clinical waste stream throughout the centre.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Quality and safety	
Regulation 27: Infection control	Not compliant

Compliance Plan for Clonskeagh Community Nursing Unit OSV-0000491

Inspection ID: MON-0036822

Date of inspection: 11/05/2022

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
1. Antimicrobial Stewardship: PIC continues to ensure monthly monitoring of HCAI/AMR/Antibiotic with consumption stats submitted to National Antimicrobial Stewardship Lead. Reports of the same are shared with the MDT locally and collectively reviewed at CHO HOS Q&S Meetings.
2. IPC Link Practitioner Nurse maintains IPC register reports, actions plans are generated and shared with MDT. IPC Link Practitioner to have support also from ADON QSSI.
3. Training for all staff being arranged to update Hand Hygiene as per train the trainer programme available.
4. Training records to be updated accordingly to ensure a true reflection of status of all training available on HSELand IPC. Hand Hygiene Audit records - Opportunity, Action Taken, Hands Prepared, Correct Technique and Action plan for hand hygiene audits.
5. IPC is standing item at all MDT and Management meetings.

6. Legionella / Water Management: Legionella issue is being addressed. Proactive Management Plan to enhance previous regular legionella testing is being developed by stakeholder group (Senior Management, Person In Charge, Unit Manager, HSE Legionella lead, HSE Maintenance officer, ADON QSSI, Household Manager). Water Mgt Plan includes Chemical flushing of systems planned for early August with subsequent re testing and continual recorded daily flushing.

7. Sharps Bins compliance enhanced to ensure audited weekly. Correct Management reinforced at Mgt Meetings and MDT.

8. PIC Confirms all nebulizer administration sets are now single use only. All CNM's made aware of correct use of same.

9. Infection Prevention training matrix is being developed for the service and will be in

use from 15/08/2022.

10. Bedpan washer usage: All Clinical and Household staff were informed and additional laminated posters were placed to ensure all staff are aware of the correct usage. Mgrs to ensure all agency staff made aware as part of induction.

11. ADON of Quality Safety Service Improvement is now in post and supporting our CNU. Through central management, the GM has set up a regular collective meeting with ADON QSSI with the intention of supporting local IPC initiatives and identification of quality improvement. First meeting 26/07/2022.

12. ADON QSSI will make regular site visits and support local audit of IPC practices / Link Pratitioner.

13. Four additional nurses will commence the National IPC Link Practitioner Programme training in September 2022.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	30/09/2022