Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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:	15 February 2022
Centre ID:	OSV-0000491
Fieldwork ID:	MON-0036246

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:	78

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
Tuesday 15 February 2022	08:45hrs to 19:05hrs	Jennifer Smyth	Lead
Tuesday 15 February 2022	08:45hrs to 19:05hrs	Siobhan Nunn	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 designated centre. Inspectors observed many positive interactions between staff and residents. Overall, inspectors observed a relaxed environment throughout the day of the inspection. However improvements were required within governance and management systems which did not ensure that a safe service was delivered at all times.

When inspectors 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 temperature checks. The centre was in COVID-19 outbreak on the day of inspection.

Clonskeagh Community Nursing Unit is divided in to four household units within the same building. There was access to two enclosed gardens, with raised beds and seating which was available to residents and their visitors. Residents were observed walking outside in the garden with their family members. Visitors indicated that they felt welcome by staff. They said that they were kept updated regarding their loved ones condition and that they were well cared for.

Inspectors spoke directly with residents, and their feedback was positive, stating that staff who delivered their care were kind and caring. Inspectors observed that staff greeted residents by name and residents were seen to enjoy the company of staff. Staff spoken with were knowledgeable of their role and reported that they were well supervised and supported. Interactions between staff and residents were seen to be courteous and respectful.

Overall, the centre was homely with bright decor. However inspectors observed that some areas of the premises required attention including wall and ceiling décor, with wallpaper peeling in some residents rooms. Residents had made colourful decorations for Valentines Day which were displayed on walls throughout the designated centre. Inspectors saw that a number of bedrooms were personalised with residents' family photographs, ornaments and other personal memorabilia. The inspectors noted that a green light system was used when staff provided personal care to maintain residents' privacy and dignity.

Inspectors observed that because of the recent outbreak of COVID-19, some of the residents were socially isolating in their bedrooms. The centre had cohorted residents who had symptoms and those who tested positive for COVID-19 in one area. Inspectors were told the areas were separately staffed with a nurse responsible for each area. Hand sanitizers were available at numerous locations and the inspector observed staff donning and doffing (putting on and taking off) PPE and found that the principles of best practice were applied.

Residents were very complimentary about the food and the inspectors saw that residents were offered choice of meals. Menus were displayed and staff also informed residents regarding the choices on offer.

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

Inspectors were not assured that management systems were effective in ensuring the service provided was safe, appropriate, consistent and effectively monitored. The gaps observed by inspectors are detailed under the regulations relating to governance and management, premises, infection control, fire and notifications.

The designated centre had a clearly defined management structure with identified lines of authority and accountability. It is operated by the Health Service Executive, who is the registered provider.The management structure includes the person in charge, who was supported in their role by two assistant directors of nursing (ADON) and the general manager for Older Persons services in CHO6. However the ADON posts were not filled, and the clinical nurse managers were covering on a rotational basis. This deficit in management had an negative impact on clinical oversight, which is discussed further in Regulation: 27 Infection Control and Regulation 5: Individual Assessment and Care Plan. Minutes of management meetings provided, showed that two meetings were held in 2021 with all senior management in attendance. Quality and risk meeting agendas included the risk register, incident management and review, health care associated infections, health and safety and training.

Following findings in relation to Regulation 28: Fire precautions on the previous inspection a fire safety risk assessment was carried out, however no action was taken to address the findings.

On review of records inspectors found that a serious incident had not been reported to the Chief Inspector in line with the regulations as per Schedule 4. Learning had been identified but interventions had not been put in place to avoid a repeat incident. The oversight of moving and handling practices, did not identify the communal use of equipment which was not prescribed. This was not in accordance with the designated centre's own standard operating procedure.

Quarterly returns did include physical restraints but did not include all of the restrictions in place in the designated centre. Environmental restraints were not included in the quarterly report to the Chief Inspector.

Audits were being carried out in hand hygiene, environmental hygiene, care plans, nursing metrics and infection control. However findings from these audits were not

seen to be actioned. Policies and procedures as set out in Schedule 5 were in place and available to all staff in the centre. Relevant policies for the management of the COVID-19 pandemic had been developed. These included infection control, visiting and cleaning protocols.

An annual review was available for 2020.There was little evidence of consultation with the residents or their families in this review.The person in charge was working on the 2021 annual review. There had been no resident focus group meetings held in 2021, but questionnaires had been issued to families and residents. 11 were returned with mainly positive feedback.

Staffing levels were sufficient to provide care and meet the needs of the residents on the day of inspection, however there were staffing vacancies at the time of inspection. One advanced nurse practitioner post and an ADON post were vacant.

There was an effective complaints procedure in the centre. This was displayed throughout the centre. There was a nominated person who dealt with complaints and a nominated person to oversee the management of complaints. The centre considered all feedback received both verbal and written and there was evidence of effective management of the complaints viewed with the satisfaction of the complainant recorded. A comments box was available. It was checked weekly and a record kept.

Staff confirmed that they had access to appropriate training to support them in ensuring residents' care needs were met in accordance with best practice. The training matrix records showed that staff had completed mandatory training in safeguarding vulnerable adults, manual handling and a suite of other relevant courses in infection prevention and control. However it was noted from the record provided that a number of staff had not attended fire training in 2021. Gaps in fire training had been found on the previous inspection on 10 September 2020, and the provider had given assurances staff would receive annual training.

Records showed that all nurses working in the centre had an active registration with Nursing and Midwifery Board of Ireland (NMBI).

Regulation 16: Training and staff development

The training matrix records showed staff had not completed all mandatory training, from the record provided 26 staff had not attended fire training in 2021. This was an area previously identified in the last inspection in 2020.

Judgment: Substantially compliant

Regulation 23: Governance and management

Management systems did not ensure the services provided were safe, appropriate, consistent and effectively monitored.

- Managers failed to recognise the risks associated with the practice of locating cleaning chemicals in residents rooms, and the preparation of these chemicals in unlocked shared bathrooms. For example inspectors saw chemicals in various stages of preparation in unlocked shared bathrooms on the Sycamore and the Chestnut units. Chemicals were seen in resident en-suites, throughout the designated centre. One en-suite had a cleaning chemical in a hand sanitizer bottle. All cleaning chemicals were removed from resident rooms and bathrooms by the end of the inspection.
- Management of fire safety risks highlighted on the last inspection on 10 September 2020, and also through a fire safety audit in November 2020 had not been addressed.
- Findings from audits and investigations were not seen to be actioned in a timely manner, for example an incident occurred in April 2021, the investigation did not conclude till July 2021. Recommendations from this investigation had not been implemented. The standard operating procedure devised had not been followed in relation to the use of certain equipment. The investigation into the incident had learning outcomes identified. However inspectors were provided with correspondence identifying the same issues, nine months later.
- Whilst there was an annual review available for 2020, it was not seen to be prepared in consultation with residents and their families.
- Reduced managerial and clinical oversight evidenced by two management meetings occurring in 2021 and two senior nursing posts being vacant, resulted in clinical audit findings not addressing issues in care planning and infection control that were found on inspection.

Judgment: Not compliant

Regulation 31: Notification of incidents

All incidents had not been notified to the Chief Inspector

- An incident resulting in an injury to a resident had not being reported to the authority within the regulatory time frame.
- Staff informed the inspectors of an alleged safeguarding incident on the day of inspection of an inappropriate use of equipment. This incident was involving improper use of equipment, which was not notified to the authority within the correct time frame.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was an effective complaints procedure in the centre. This was displayed throughout the centre. There was a nominated person to oversee the management of complaints.

Judgment: Compliant

Regulation 4: Written policies and procedures

Policies and procedures as set out in Schedule 5 were in place and available to all staff in the designated centre.

Judgment: Compliant

Regulation 15: Staffing

There were sufficient staffing resources with the right skill-mix in place for the number of residents and the layout of the centre.

Judgment: Compliant

Quality and safety

Inspectors found that residents experienced a good quality of life as a result of the services provided in the designated centre. They were able to make choices about their meals and how they spent their day. However improvements were required in the areas of, infection control, fire, premises,care planning and the management of risks.

Residents had good access to health care professionals with regular visits from the GP. Occupational therapy and physiotherapy assessments were completed when required and inspectors saw evidence of residents specialist equipment being repaired, cleaned and replaced when residents assessed needs changed. When required residents were referred for assessment by palliative care services and

psychiatry of later life.

Multiple clinical assessment tools were used to assess residents' needs, however inspectors found that assessments had not been completed on two residents to use specific hoist slings, and care plans had not been developed to guide staff. Care plan reviews had not been completed within four months on the resident files viewed by inspectors.

The registered provider had measures in place to protect residents from abuse. A safeguarding statement was displayed in the reception area. The registered provider managed pensions for 16 residents and had flexible systems in place to ensure that residents could access their money throughout the week. Staff received training in safeguarding and a policy was in place, however not all safeguarding concerns were reported to the Chief Inspector.

On the day before the inspection residents had completed a competition to judge the best decorated unit for St Valentine's Day. Signs for access to advocacy services were displayed throughout the designated centre. Residents individual and group activities were integrated into their daily lives, and centre wide activities were organised on special occasions such as Easter and Valentines Day. Inspectors observed residents enjoying a sing along session between breakfast and lunch.

Inspectors were accompanied by the Person in Charge and Hospital Manager when viewing twin and triple rooms. The triple rooms had their occupancy reduced by one, however a reconfiguration of the layout of the rooms had not taken place. On the day of the inspection these rooms were used to store old furniture and equipment. The twin rooms were not configured to allow residents to access their belongings in private, and in one room the divider screen was not long enough to provide privacy to residents. Managers agreed to review all rooms and to take action to ensure that they were compliant with Regulation 17.

At the time of the inspection there was an outbreak of COVID 19 in the designated centre. Residents remained in their rooms to prevent the spread of infection. Staff were observed wearing FFP2 masks throughout the inspection, and staff were assessed to ensure the mask fitted properly prior to being worn. Inspectors viewed up to date monitoring records of staff and resident temperatures and signs of COVID 19.

Cleaning trollies were well organised with colour coded cloths were available for use in different areas. Cleaning checklists were used to guide staff and inspectors saw that they were signed off by managers on completion of the different tasks. However cleaning fluid was observed by inspectors in the residents rooms' they visited. A number of hoist slings were unlabelled, and stored in communal bathrooms.

Inspectors found two fire doors located on the lower ground and first floors of the designated centre that did not close properly. A fire audit had been commissioned by the Health Service Executive in November 2020 following the last inspection. Findings from this audit had not been acted upon, these included fire doors not closing properly.The audit looked at 185 fire doors including FD30'S, FD60'S and

emergency escape doors, 66 of these devices passed testing, giving an overall 36.2% pass rating.

Regulation 11: Visits

Visiting arrangements were in compliance with the latest guidance from the Health Protection Surveillance Guidance. Residents had the option to receive visitors in a day room or their bedrooms or alternatively to make use of the garden space provided.

Judgment: Compliant

Regulation 12: Personal possessions

Residents were provided with lockable cupboards in their rooms to keep their valuables safe. A laundry system was in place to ensure that residents clothes were laundered regularly and returned to them.

Judgment: Compliant

Regulation 17: Premises

Inspectors viewed 2 triple rooms and four twin rooms and found that they did not have an area of 7.4 m2 of floor space for each resident which included a bed, a chair and personal storage space. These rooms were not configured to ensure that residents could access their belongings in private.

Wallpaper was peeling from the wall in a twin room and on a corridor.

Suitable storage was no available throughout the designated centre. For example:

- Triple rooms contained extra furniture including, two wheelchairs, four lockers, four wardrobes and 2 commode chairs
- Six large water bottles were stored on the floor of a residents sitting room
- A store room on the Sycamore unit was unsafe with used lockers, an old hoist and other items stacked on top of each other.

Judgment: Not compliant

Regulation 27: Infection control

The registered provider had not ensured that procedures, consistent with the National Standards for Infection Prevention and Control in Community Services (2018) published by HIQA were implemented.

Hand sanitiser bottles were being refilled, which poses a risk of cross contamination.

Hand sanitiser bottles were being refilled with cleaning fluid and left in resident's rooms. The cleaning fluids were being prepared in bathrooms which were left unlocked. This caused a safety risk to residents, as they could access the cleaning liquids.

Unlabelled toiletries were observed in resident's rooms, bathrooms and on a clean laundry trolley, which poses a risk of cross contamination if multiple residents are using these products.

Inspectors observed five unlabelled toileting and handling hoist slings stored together behind a bathroom door, which is a risk of cross contamination.

The oversight of cleaning procedures did not identify the risks related to keeping cleaning chemicals in residents rooms and communal bathrooms.

An office used by the occupational therapy service was being used to store a number of items including a stepladder, a printer and boxes of paper on the floor which did not allow for proper cleaning.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Inspectors were not assured that there were adequate arrangements in place to protect residents in the event of a fire emergency. Inspectors found;

• A number of fire doors located on the lower ground and first floors of the designated centre that did not close properly.

• A fire audit had been carried out by a fire company in November 2020 following the last inspection, their findings had not been acted on, these findings included fire doors not closing properly.. The audit looked at 185 fire doors including FD30'S, FD60'S and emergency escape doors, 66 of these devices passed testing, giving an overall 36.2% pass rating. Works to rectify these doors is now planned to place on the 9 March 2022.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed the records of 4 residents in detail. Care plan reviews had not taken place within 4 months in 3 of the records viewed. This meant that staff did not have up to date guidance when delivering care to residents. Notes were observed on residents files following audits to remind staff to review care plans, but there was no evidence of the reviews taking place or the audit being followed up..

Assessment and care planning had not taken place for one resident in relation to the use of a toileting sling, which resulted in a physical risk to the resident.

Another resident was assessed as requiring a hammock sling but inspectors were shown a toileting sling which was being used for the resident. Although a toileting sling had been requested it was not recommended in the assessment, thus resulting in a physical risk to the resident.

Judgment: Not compliant

Regulation 6: Health care

Residents had regular access to their GP. Referrals were made when required to allied health professionals including occupational therapy, physiotherapy therapy, and speech and language therapy. Residents also received services from Psychiatry of Old Age and Palliative care when necessary.

Judgment: Compliant

Regulation 8: Protection

An alleged safe guarding concern raised by staff on the day of inspection had not been recognised or reported to the Chief Inspector. An investigation had been completed, and the matter was escalated to senior management in the HSE for review. Inspectors requested a NFO6 to be submitted following the inspection, this notification is yet to be submitted to the office of the Chief inspector.The provider have failed to follow the requirements of their own safeguarding policy.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents in twin rooms did not have choice in relation to their personal space. Inspectors observed a resident being disturbed while sitting, every time the privacy screen was moved for the other resident. Residents were unable to watch TV in private in twin rooms. The curtain in one room was not long enough to provide privacy to the resident.

Resident focus group meetings did not take place in 2021.

Judgment: Substantially 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	
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Regulation 15: Staffing	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Clonskeagh Community Nursing Unit OSV-0000491

Inspection ID: MON-0036246

Date of inspection: 15/02/2022

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: There is a plan in place for fire training. Fire training continues to be provided to the staff subject to trainer's availability. 2020 • 18/11/2020 • 19/11/2020 2021 • 02/03/2021 • 19/03/2021 • 25/06/2022 • 14/07/2021 • 16/12/2021 • 09/12/2021 2022 • 11/03/2022 • 01/04/2022 • 26/05/2022 In house trainers provide ongoing CPR, Manual Handling and Dementia/butterfly training.	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: ADON campaign is complete and is at the final stage on 06/05/2022 CNM II campaign has concluded and is at the final stage on 06/05/2022 Antichlor bottles are now stored in locked areas. All Nursing and Household staff have been reminded of safe practices and our management of dangerous goods policy. Re: Manual Handling- Recommendation was to incorporate MDT in carrying out Manual Handling assessments and the same has been implemented across our service. Nurses, Physiotherapist and Occupational Therapist will continue to complete Manual Handling assessments. Inspectors were informed about the updated manual handling assessment form on the day of inspection. Two management meetings referred to are the meetings between GM and PIC. Outside of these meetings the GM is available and attends regularly for unannounced meetings with the PIC and Unit Manger. The PIC also participates in collective CHO6 DON /GM Meetings. The Registered Provider also chaired Q&S CHO6 Meetings. The Registered Provider and GM participate with QSSI Colleagues on SIMT meetings as relevant to CCNU. CNM meetings and QSR meetings are scheduled periodically during the year. Care Planning: All issues were rectified.	
Regulation 31: Notification of incidents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: Environmental restraints: During inspection, the HIQA Inspector advised that floor beds should be notified as restraints. At the time of inspection none of the residents who were mobile and could walk unassisted were provided with floor beds as restraints. Chemical restraints: During the inspection HIQA Inspector advised all prn psychotropic medication must be notified as chemical restraint. However, all residents with prn medication had clinical indications and none of the prn medication was prescribed by the medical officer as chemical restraint. Safeguarding incident using improper use of equipment: This will be discussed with HSCP staff working in Clonskeagh community Nursing Unit as agreed on the provider's call on 27/06/2022.	

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
An overall decluttering was completed and all additional equipment and storage containers were removed.

Our area Chief Assistant Technical Services Officer from HSE Capital and Estates has been on site and met with the PIC to review resident living spaces to ensure compliance with S.I. No. 293, 2016. Proposed works have been identified to ensure residents can enjoy not less than 7.4m² as personal space.
Contractors are scheduled to attend before 08/07/2022 to develop plans and estimates for the works to be completed. The proposed reconfiguration works of some wardrobes, lockers and room dividers so as to adequately achieve 7.4m2 will be completed by 31/10/2022. These plans will be submitted to the Inspector as soon as they are to hand but no later than the 22nd of July.

In addition, the Registered Provider Representative has instructed that the 3 bedded short-stay respite rooms to be utilized for no greater than 2 persons until 30/09/2022.

It should be noted at this point that the Respite Rooms (3 bedded rooms) are not in use at present but it is the intention of the Provider to incrementally re-introduce respite to the facility subject to ongoing guidance from the Dept of Public Health and in line woith all appropriate IPC measures.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
All residents have personalised toiletries, additional slings were removed and stored remotely. Excess toileting slings were removed and as appropriate sent to storage.

Cleaning chemicals now are in locked areas. No inappropriate vessels are being used to store cleaning products or hand sanitisers.
The refilling of hand sanitiser containers was a leqacy issue from a time early in the pandemic when the sanitiser was only available and being delivered in bulk containers. This practice has long since changed and all re-filling practices stopped.
All Household Staff have been informed and line management are reinforcing best practice.
Each CNM and Nurse will remain vigilant to all IPC practices.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire Door remedial work was completed and certificate of completion received on 15/04/2022

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Care plans noted as non-compliant at the time of inspection are now fully updated.
Audits of all Care Plans and appropriate communication in advance of due dates for review are in place and the responsibility of CNMs.

Manual Handling assessments are carried out with MDT and adequate record of the assessments and recommendations are added to Residents Care Plans.
Two Manual Handling Trainers will form part of the manual handling assessments to make them more comprehensive and collaborative from June 2022.
All excess slings have been removed for common areas.
New referrals from OTs for specialist sizing in our sling stocks have been approved and purchases will be arranged to ensure adequate access and supply.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Factually inaccurate. As agreed on the HIQA and Provider's Representative call on 27/06/2022, this item will be addressed with HSCP Staff working in Clonskeagh Community Nursing Unit to ensure no ambiguity or miscommunication arises in the future.

No serious safeguarding concerns were withheld from HIQA after inspection.

Clonskeagh CNU also participated in Feb 2022 in an external audit of Safeguarding conducted by National Safeguarding Office. Safeguarding remains a priority for all our staff.

Safeguarding incident using improper use of equipment: This will be discussed with HSCP staff working in Clonskeagh community Nursing Unit as agreed on the provider's call on 27/06/2022

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Overall review of the living spaces to ensure compliance with S.I. No. 293, 2016 will be completed to ensure not less than 7.4m² is available as personal space for our Residents

Resident forum will recommence and be scheduled as soon as practical upon closure of the current covid outbreak.

To continue consultation via: Satisfaction Survey, CEOL feedback and catering circle meetings. Dietician will be commissioned to support an overall review of food options, which will be done in consultation with residents and their families.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	26/05/2022
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/10/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/05/2022
Regulation 23(e)	The registered provider shall ensure that the	Not Compliant	Orange	31/07/2022

	review referred to in subparagraph (d) is prepared in consultation with residents and their families.			
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.	Substantially Compliant	Yellow	15/02/2022
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	15/04/2022
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	15/04/2022
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	15/04/2022

Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Substantially Compliant	Yellow	26/05/2022
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	16/02/2022
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs	Substantially Compliant	Yellow	30/08/2022

	7(2) (k) to (n) of Schedule 4.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	20/02/2022
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	09/05/2022
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	15/02/2022
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	31/08/2022
Regulation 9(3)(b)	A registered	Substantially	Yellow	31/10/2022

	provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Compliant		
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	30/05/2022