Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

Centre name:	Sacred Heart Hospital, Roscommon
Centre ID:	0654
Centre address:	Golf Links Road
	Roscommon
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Type of centre:	☐ **Private** ☐ **Voluntary** ☒ **Public**
Registered provider:	Frank Murphy
Person in charge:	Julie Silke-Daly
Date of inspection:	04 January 2011
Time inspection took place:	**Start:** 10:40 hrs **Completion:** 19:20 hrs
Lead inspector:	Catherine Connolly-Gargan
Support inspector(s):	Bríd McGoldrick
Purpose of this inspection visit	☐ Application to vary registration conditions ☐ Notification of a significant incident or event ☐ Notification of a change in circumstance ☒ Information received in relation to a complaint or concern ☒ Follow-up inspection

About the inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the Standards. It also ensures that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Additional inspections take place under the following circumstances:

to follow up on specific matters arising from a previous inspection to ensure that the action required of the provider has been taken following a change in circumstances; for example:

- following a notification to the Health Information and Quality Authority's Social Services Inspectorate that a provider has appointed a new person in charge
- arising from a number of events including information received in relation to a concern/complaint or notification to the SSI of a significant event affecting the safety or well-being of residents
- to randomly "spot check" the service.

All inspections can be announced or unannounced, depending on the reason for the inspection and may take place at any time of day or night.

All inspection reports produced by the Health Information and Quality Authority will be published. However, in cases where legal or enforcement activity may arise from the findings of an inspection, the publication of a report will be delayed until that activity is resolved. The reason for this is that the publication of a report may prejudice any proceedings by putting evidence into the public domain.

About the centre

Description of services and premises

The Sacred Heart Hospital is operated by the Health Services Executive.

The centre provides continuing care, rehabilitation and respite care for up to 107 people from the Roscommon area. Nine places are allocated for rehabilitation and three for palliative care. The centre accommodates six residents aged less than 65 years and the remaining 89 beds for continuing care of older people. A day care service is also available on site.

Part of the building dates from 1842 and refurbishment has taken place down through the years most recently, in St Catherine's Unit. There are four units, St. Catherine's, St. Joseph's, St. Michael's and Our Lady's Unit which is a secure unit providing accommodation for twenty residents with dementia care needs.

Although some single accommodation is provided on St Catherine's Unit, each of the units provides accommodation arranged in multiple-occupancy areas for between two to five residents. Three single rooms with en suite toilet, shower and hand-washing facilities, called the "sunflower suites" are available in St. Joseph's and Our Lady's Unit to provide palliative care accommodation. There is a designated occupational and physiotherapy service in accommodation adjacent to the centre.

There is car parking to the front and to the side of the building.

Location

The Sacred Heart Hospital is located on Golf Links road, a short drive from the shops and business premises of Roscommon Town, County Roscommon.

Date centre was first established:	1842
Number of residents on the date of inspection	93 + 2 in hospital
Number of vacancies on the date of inspection	0

Dependency level of current residents	Max	High	Medium	Low
Number of residents	29	34	23	7

Management structure

The Person in Charge, Julie Silke-Daly reports to the HSE General Manager, Michael Tobin and the Local Health Manager, Frank Murphy.

Two assistant directors of nursing and a team of nine clinical nurse managers are responsible for supervising the delivery of care and report to the Person in Charge. They are supported by staff nurses, care assistants, a pharmacist, and administrative, clerical and ancillary staff. A multidisciplinary physiotherapy, occupational therapy and medical staff team complete the staff profile.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other Staff
Number of staff on duty on day of inspection	1	*11	17	6	1 x laundry 3 x cleaning and kitchenette staff	9	**12

*3 x clinical nurse managers, 6 x staff nurses, 2 x assist directors of nursing

**5 x maintenance staff, 1 x stores person, 4 x physiotherapy staff, 2 x occupational therapy staff

Background

The Health Information and Quality Authority (The Authority) carried out a scheduled inspection of the centre on 28 and 29 of September 2009. An action plan identifying fourteen areas for improvement was developed from findings of that inspection. The provider's response was returned on the 23 December 2009.

Two concerns were received by the Authority since the scheduled inspection relating to medication management, protection and healthcare. During this follow-up inspection, the inspection team confirmed that medication management was not of an adequate standard in a number of areas. An Garda Síochána vetting was either received or in process for each staff member.

All staff had completed training in elder abuse recognition and prevention in 2008 and nearly 50% of staff have completed a refresher course facilitated by a staff trainer and the elder abuse officer. Wound care management was of an acceptable standard and specialist wound care support and equipment was utilised accordantly.

However, two residents had pressure related ulcers, one of which was a grade two wound which was not notified to the Chief Inspector of Social Services as required by the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Summary of findings from this inspection

This report references findings of an unannounced one-day follow-up inspection by the Authority. The focus of the inspection was to monitor compliance with requirements identified in the action plan from a scheduled inspection of the 28 and 29 September 2009 relevant to governance, quality of service, healthcare management, staffing, communication and environmental matters

In addition, the inspectors focussed on key aspects of service delivery to assess the extent to which the management of care ensured high quality, positive and safe outcomes for residents. Inspectors reviewed areas of resident care highlighted in concerns by the public to the Authority. An analysis was completed of the notifications received to the Authority since the previous inspection.

The inspection process included discussion with residents, the person in charge and staff. Documentation examined included care plans, medical records, fire safety records, operational policies and procedures, accident and incident records, audit documentation and the complaints register. The inspectors also had an opportunity to review the environment and observe care practices.

The person in charge was familiar with the day-to-day running of the centre. Any documentation requested was made available.

The designated provider Mr Frank Murphy visited for meetings as scheduled but was not actively involved in the running of the centre. Inspectors were given information post inspection that a new acting provider was in place.

Residents interviewed were complimentary of the service provision and spoke highly of the staff.

Inspectors found that three actions in the action plan of the 28 and 29 September 2009 had been completed to a satisfactory standard. The remaining eleven actions were not satisfactorily completed and were all outside the completion dates agreed. There were three recommendations and although the provider has not documented a response on plans to resolve these deficits, inspectors found that these areas were partially resolved and have been restated in the action plan at the end of this report.

The most significant positive development was the refurbishment of St Catherine's Unit, which has seven multi-occupancy rooms and three palliative care rooms (although one of the palliative care rooms is located in Our Lady's dementia care unit). This work improved the quality of life and environment for residents accommodated in St Catherine's Unit and in the palliative care rooms. Inspectors were told by residents that the addition of communal areas, single bedrooms for end of life care and the introduction of relaxation areas and restful spaces throughout had improved their quality of life.

Inspectors found that although local efforts had been made to address some areas of deficit such as activity provision, care planning, review of communal and private space for residents, these were inadequate in fully meeting the needs of the residents. For example, the recreational and social needs of all vulnerable and dependant residents were not assessed. While beds were reduced to increase communal and private space for residents, the vacated bed areas were used for storage space. Fire safety and risk management was of an inadequate standard and residents were at risk as a result.

Areas requiring significant improvement included medication management practices and systems, restraint management, fire safety management, risk management and access to healthcare for residents. Improvements were also required related to nursing care documentation which did not accurately detail residents' social care needs and emotional health. Infection control and cleaning was not of an adequate standard. Environmental issues and the hours worked by household and cleaning staff were identified as areas that required attention. Issues such as fire safety, risk management, inadequate staffing levels, restraint management, hygiene standards and medication management (prescribing, recording and administration practice) were brought to the attention of the person in charge at the feedback meeting and with the provider at a meeting on 17 January 2011.

The action plan at the end of the report identifies areas where improvements were required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and the *National Quality Standards for Services for Older People in Ireland.*

Issues covered on inspection:

Ordering, Prescribing, Storing and administration of medicines
Nurses were the only key holders for the medication trolley and cupboards. The medication trolley was locked and stored in the medication room. There was a medication policy with procedures for prescribing, administering, recording and storing of medication. Staff wore a red apron alerting other staff that they were completing resident's medication dispensing procedure. Controlled drugs were stored safely in a double locked cupboard. Recent photographic identification was attached to each medication chart. Staff were knowlegable about medication use. The speech and language therapist and a number of nurses including a clinical nurse manager were actioning a project to improve bowel function. This involved a review of medications used for each resident involved. However, residents were not safeguarded from all risk of an adverse medication incident.

Although a medication management policy was in place, it did not reference all aspects of residents' medication therapies in the centre, for example, PRN (as required) medications, nebulised medications and injections. Inspectors observed that in practice this area of resident care was of an inadequate standard and failed to meet legislative medication management practices in a number of areas. Residents medications were not reviewed three monthly. There was evidence that medication prescribing practices were not resident centred but reflected institutional practices. Inspectors found that there were blanket prescribing practices of 'as required' (PRN) bowel preparations, paracetamol and anti sickness medication.

A number of medications were prescribed for each resident with specified administration frequencies and for PRN administration. In one instance the medication administrator was required to make a selection between a controlled drug and paracetamol as they were both were prescribed on the same line. The text indicating the PRN (as required) section of the computerised medication prescription sheets was removed from the typed copy of a large number of the medication prescription sheets reviewed. Maximum drug dosages in each 24 hour period were not recorded on PRN prescriptions. Flu vaccine prescribing was of an inadequate standard.

There was no record of any medication errors or adverse reactions in relation to residents. Discontinuation of residents' medications was not signed and dated on the prescription sheet.

The centre had a stocked pharmacy. A pharmacist worked part-time and attended the centre after hours three days each week. The director of nursing and the assistant directors of nursing had access to the pharmacy and were involved in dispensing drugs required for residents in the centre. However, there were no documented dispensing guidelines available to guide their practice. The pharmacy medication fridge temperature monitoring records referenced the last measurement taken on the 29 June 2010.

Management of controlled drugs at Unit level was not adequate as balances were not checked and documented for each drug as required by professional and legislative regulations. While controlled drugs were restocked by the pharmacist at unit level, the

ward staff did not have procedures in place to check balances at each change of shift in line with professional standards.

A significant number of residents were receiving nebulised medications. While the medication management policy did not reference this medication therapy, there was no documented procedure in place to instruct staff on evidence based nebuliser mask changing frequencies. Staff told inspectors that although nebuliser machines were cleaned regularly, masks were changed when they were visibly soiled.

Fire Precautions and Records
A fire plan was displayed on entry to the building but notices to indicate the procedure to be followed and the nearest exit in the event of a fire were not in place. Management of fire safety was not of an adequate standard to minimise risk to residents in the centre. A staff employee was a part-time member of the statutory fire services. He assisted with fire procedures and training in the centre. However, there was no evidence to support completion of a familiarisation visit to the centre by the statutory fire services. All staff had not attended a minimum of six monthly drills where they had opportunity to participate in a practice evacuation of residents from a simulated fire point. Evacuation procedures referenced blanket evacuations of dependant residents. However, residents did not have individual risk assessments completed that identified the numbers of staff and equipment required to remove them safely in the event of a fire. An incident was recorded on one of the units referencing where a resident was smoking in bed and had burnt holes in the sheets. Another incident recorded where the call bell was disconnecting the fire alarm. This was corrected. While fire exit directional signage was not lighting in a number of areas, many large fire exit directional signs were in text only. All areas of the centre did not have sufficient signage to direct occupants to nearest fire exit.

Fire compartmentalisation was in place. Directional signage, appropriate fire procedures and exit directions were not available throughout the building. Fire exit doors had four different closure mechanisms including keys, push bar, electromagnetic systems and thumb locks. Inspectors were particularly concerned about the lack of procedures for those residents in the dementia unit. Inspectors reported their findings to the person in charge, staff employee and maintenance manager on the day of inspection.

A list of attendees of fire training was maintained by the person in charge. No evacuation takes place at these times. Fire drills were not undertaken six monthly at the centre; consequently staff did not routinely participate in fire drills, to reinforce the theoretical training provided and ensure they were confident of the procedure to be followed in the case of a fire.

Risk Management
There was a centre-specific risk management policy available. An emergency plan was also in place and documentation was held in reception inside the front door.

Resident restraint management required review and improvement in a number of areas. Inspectors noted that the majority of residents were using bedrails or bedrails were attached to their bed frames but not engaged. Although a comprehensive policy was available in draft form, it did not reflect practice. There were also four buxton type recliner chairs, although the tables were not fitted, a bed table was placed in a fixed

position in front of the residents. Documentation was not in place referencing restraint needs assessment, monitoring and release procedures for each resident using restraint. There was evidence that some restraints were used at the request of residents' relatives. While lap belt type restraints were consented for. Consents were not available for all residents using bedrails. A review of incidents referenced a resident falling from their chair as a result of opening their lap belt on the 19 September 2010. There was no evidence of on-going review of the restraint measures or that the restraint measure was in the best interest of the resident.

Notifications did not meet the legislative standards. A resident had a grade two decubitus ulcer which was not notified to the Chief Inspector of Social Services. Quarterly notifications of accidents where residents were injured were also not sent in full to the Chief Inspector for example incident 03 August 2010 where resident required treatment in accident and emergency department, a resident fell on the 11 September 2010 and sustained a nosebleed which required packing to control. Two alleged incidents of elder abuse were also not notified to the Authority as required.

The inspector reviewed the process for recording incidents and accidents. Staff spoken with relayed a positive attitude towards reporting incidents and recorded all accidents, incidents and near misses.

A robust multidisciplinary falls management committee has been established. The senior physiotherapist leads this team. Inspectors viewed records where various risk reduction aides were used for residents who had fallen, for example, hip protectors. These actions had helped reduce the incidence of falls and a review of quarterly notifications for October to November 2010 referenced no fracture injuries.

Although there was an audit tool available for complaints, this was not completed or used to evaluate trends or areas that could be improved. Accidents, incidents and near misses were also recorded. However, logging of accidents, incidents and near misses was not consistently recorded in risk management documentation. Inspectors noted records of incidents and injuries to residents recorded in the complaints log. While there was evidence that not all accidents, incidents and near misses were recorded in the appropriate risk management documentation, there was also no clear evidence of quality review of data collected, where trends and areas for improvement were identified.

On reviewing the care files it was evident to the inspectors that some risks had been considered. Risk assessments had been carried out in relation to some health care issues, for example pressure ulcer risk assessment, nutrition, safe moving and handling, accidents and falls. On case files reviewed many assessments were not reviewed for substantial periods, for example there was poor evidence that dependency level assessments were up to date. These scales were not reviewed in the light of changed circumstances to determine the revised requirements of the resident.

Staff Training

Inspectors noted documented instances of challenging behaviour by residents in a review of the incidents recorded. Residents referenced in some of these incidents were described as 'violent'. There was evidence that twenty seven staff have attended training on managing challenging behaviour, ten of which worked in Our Lady's dementia care

unit. Dementia care training had also commenced and fifteen staff had attended out of a total of 154 nurses and care attendants. Eight of the twenty three nurses and care attendants who worked in Our Lady's dementia care unit had received this training.

Healthcare
Inspectors were told that the medical officer had recently resigned and that a locum Doctor was in post for the centre for fifteen hours each week. Although there was an on-call medical service provided by the surgery in Roscommon, residents could also attend the acute hospital which was a short distance from the centre. However residents were not facilitated to continue to be cared for by their own general practitioner (GP) or they did not have access to a general practitioner of their choice.

Residents had access to physiotherapy, occupational therapy, speech and language therapy and dental services on site. This was evident in the files reviewed. Inspectors also had opportunity to meet the physiotherapist and the speech and language therapist who were on-site reviewing residents in the centre. The speech and language therapist and a clinical nurse manager were leading out on a quality initiative where they aimed to improve residents' bowel health by identifying and reducing factors that impacted adversely to this area of resident healthcare, for example, some medications or lack of exercise or fluids.

A room was fully outfitted as a dental surgery. The person in charge told inspectors that the dentist visited regularly.

There were two residents receiving nutrition by means of a percutaneous endoscopic gastrostomy (PEG) tube. There were residents with diabetes. Some residents also had chronic wounds. Residents requiring dietetic services were required to attend the acute hospital for review. One resident receiving PEG feed therapy was receiving end of life care and was unable to travel to the acute services for review due to her poor health and therefore could not avail of this service as the dietician did not attend the centre.

Assessments and care plans focused on a medical model of care, for example, care plans referred to the risk of falls and other physical health problems. There was limited evidence available that residents were actively consulted with regard to the development of their care plan or its review. There was no narrative in the case notes describing the consultation about the care plan development or review. Where residents had dementia or were cognitively impaired, there was no narrative detailing the assessment of the capacity of the resident to consent to the care plan. Care plans were not consistently evaluated as required, for example, each time their condition changed or regularly every three months. There was limited evidence that an assessment of social care needs had been undertaken and there was no emphasis on interventions within care plans on the need to promote social aspects of care.

Inspectors were told that a full review of care planning had taken place in conjunction with the Nursing Planning and Development Unit. The person in charge discussed how the new model of care was selected by the centre because of its focus on the social, spiritual and psychological care of residents. However, training is required for all staff prior to its introduction. This training project has not commenced to date.

Resident Records/Confidentiality
Management of residents' personal information relating to their assessments and care was not maintained with confidentiality in all aspects. Inspectors observed residents' medical charts stored in trolleys which were accessible to the public. Instructions to staff regarding residents' therapies and care were displayed by some residents' bedsides.

Medical records were not reviewed on a three monthly basis for each resident. Archived records were not easily retrievable and were not tagged for tracking purposes. Inspectors observed residents records being placed in boxes in no particular order.

Statement of Purpose
A recent review of the centre's statement of purpose had taken place. However, it required some further revision to meet legislative requirements. For example, the organisational structure required expansion and clarity was required regarding the maximum numbers of residents who will be accommodated in the centre. Reference to how residents or their next of kin were involved in the pre-admission assessments which were undertaken by a committee was not documented.

Complaints
There was a complaints policy for the centre and it was displayed. There was a nominated person to deal with complaints. A review of the complaints log in one unit confirmed that verbal complaints were recorded.

However, this review of the complaints register did not exclusively reference complaints but also included incidents of injuries to residents and maintenance issues for example, a broken blind. There was no documentation recording the complainants' satisfaction with outcomes. Inspectors noted a suggestion/comment box. It was opened monthly. Residents confirmed that if they had a complaint they would talk to the person in charge or the nurses. All residents spoken with confirmed that they were satisfied with the service provided and had no complaints at the current time.

Premises
The infection control nurse in the acute hospital setting is available for advice and support for the centre. Inspectors observed hand cleansing gels available throughout the centre. However, equipment and surfaces were not clean. Commodes were dirty and inspectors observed stale urine in one commode which was in place ready for use. Some surfaces were not in a good state of repair and were difficult to clean. For example tiles were broken in one of the bathrooms. A review of notifications sent to the Authority for 2010 referenced an outbreak of vomiting and diarrhoea in January 2010 where nine residents were affected.

Inspectors viewed structural work that had being completed to a good standard. St Catherine's Unit, external paving and landscaping, palliative care rooms, upgrade of kitchens and sluices had all been refurbished since the previous inspection in September 2009. A barbecue was purchased in response to a request by the residents' council. Residents were observed going out into the well landscaped and safe gardens. Specialist ceiling hoists were installed in St Catherine's Unit making best use of available space. Residents had access to an oratory on one of the units in addition to the church; it was furnished appropriately and to a high standard. A smoking room was available for residents in St Catherine's Unit. It was permanently ventilated to the external air.

However, the corridor floor in Our Lady's unit was observed to be in an unsafe state. Manholes were covered with timber and were not level with the existing floor creating a trip risk. Inspectors were told that management were awaiting an external contractor to complete this work. However, adverse weather conditions had delayed the schedule for completion. Vulnerable residents in Our Lady's dementia unit were at risk of scald injury from a hot water boiler in the kitchenette which was not secured. Vulnerable residents were also at risk in one of the units of ingestion injury from cleaning agents and medication stored in the bathroom.

Grab rails were not in place on both sides of toilets and showers to assist and promote independence of residents who may be unsteady and at risk of falling. Residents were unable to reach light switches and inspectors noted residents having difficulty operating the electronic water dispensers. Although staff changing facilities were provided, a shower was not available.

Actions reviewed on inspection:

1. Action required from previous inspection:
There was no cleaning /domestic staff available in the centre after 14:00 hrs. This compromised infection control arrangements and diverted care and nursing staff from their specific roles and responsibilities.

The provider shall ensure that at all times the numbers and skill mix of staff are appropriate to the assessed needs of residents and the size and layout of the designated centre. Cleaning and household staff must be available throughout the working day.

This action was not satisfactorily completed. A household standards committee has been established and developed a number of comprehensive cleaning standards. For example 'that all bathrooms and toilets within the Unit/Department will be maintained in a clean state at all times'. However this standard was only met in St Catherine's Unit and the three public toilets.

Evidence was available in the duty rota referencing extended hours to provide cleaning in St Catherine's unit up to 18:00 hrs for four days each week. Other than these four days none of the units had cleaning services available after 14:00 hrs. Inspectors also found that there was no cleaning staff rostered on duty in two units on the day of inspection. Resident equipment, floors and surfaces were not clean and in some cases heavily stained. Cleaning schedules were not in place and the cleaners' rooms were not of an adequate standard.

In one unit a member of staff scheduled to do cleaning and kitchenette duties was completing care assistant duties due to staff shortages. Soiled linen was observed in toilets in Our Lady's dementia care unit. Inspectors were told that a training programme was planned but to date had not been delivered to staff. However, the evidence supported inadequate cleaning and household supervisory arrangements in place. This action is restated in the action plan at the end of this report.

2. Action required from previous inspection:
The information included in staff personnel files did not meet current legislative requirements or provide the required level of protection for residents.

Evidence of the outcome of Garda Síochána vetting was not available in files and induction programmes had not been fully completed.

The provider shall maintain all the documents outlined in Schedule 2 including the outcomes of Garda Síochána vetting in staff files.

This action was satisfactorily completed. Staff files were held centrally. The person in charge confirmed that all staff had applied for An Garda Síochána vetting. Some applications were satisfactorily completed, while others were in process. All staff had completed elder abuse recognition and prevention training. Induction procedures could not be reviewed as no new staff had been recruited to date.

3. Action required from previous inspection:
The hot water was very hot to touch and presented a risk of injury to residents.

The registered provider shall provide thermostatic control valves or other anti-scalding protection on all hot water taps used by residents.

This action was partially completed. Although thermostatic hot water valves had either been installed at point of contact or centrally at the point of distribution, there was no evidence to support water temperature monitoring arrangements. The temperature of one of two hot water outlets measured in Our Lady's dementia care unit measured 44.9 degrees centigrade. This action is restated in the action plan at the end of this report.

4. Action required from previous inspection:
The communal sitting and dining areas did not provide adequate space for all residents to use the areas in comfort. Residents did not have sufficient space to move around independently at mealtimes.

The provider must make available appropriate private and communal space for all residents throughout the centre.

This action was partially completed. Resident sitting and dining areas had recently been refurbished. However, inspectors noted that residents tended to stay by their bedsides in some units for their meals. Some residents said this was their choice. This action is restated in the action plan at the end of this report.

5. Action required from previous inspection:
The ward kitchens did not have adequate space or equipment to enable staff to work safely. Wash hand basins were not available and the volume of crockery was too excessive to manage in the confined space.

Provide an adequate facility to wash and dry ward crockery.

This action was satisfactorily completed. A central dishwashing facility is in place. All crockery used by residents is transported to this point and redistributed at mealtimes.

6. Action required from previous inspection:
The social care needs of residents were not consistently described in care records. In particular the social care of residents who are very frail or who had memory problems were not adequately identified or addressed.

The provider must have in place a system to identify the social care needs of residents who are very frail or who have memory problems and provide recreation and relaxation opportunities.

This action was partially completed. Staff are currently undertaking training on an accredited activity project. Although this programme has not been fully implemented, staff had commenced introducing some new meaningful activities. For example a pet visit had taken place, a hairdressing room was opened and a reminiscence folder had been developed and was in use. A stimulation therapy room was also made available.

Plans were in place to introduce a new model of care that addressed physical care needs but placed greater emphasis on assessment of resident's social, spiritual and psychological needs. However a prolonged training schedule was required to assist its introduction while ready had not commenced to date.

An activity therapist worked from 13:00 hrs to 17:00 hrs daily. An activity assessment had not been completed for all residents but especially residents with dementia or under 65 years. Although there were recreational activities available, a schedule of these activities was not prominently displayed at points to enable residents to make choices about which ones they would attend. As Our Lady's Unit was a secure unit and residents there had varying levels of cognitive impairment, there was no evidence of an activity programme specifically tailored to meet the needs of this vulnerable resident group. One resident told inspectors that she wanted to leave and was observed on a number of occasions throughout the day of inspection trying to leave each time the door was unlocked. Another resident under 65 years felt 'down in the dumps' and bored. There was no evidence of a diversional therapy programme developed or in use to help unsettled residents or specialised recreational programmes for residents under 65 years. This action is restated in the action plan at the end of this report.

7. Action required from previous inspection:
There were no hand-wash basins in critical activity areas such as kitchens and sluices where good infection control management is vital for safety and well being.

Wash-hand basins must be provided in each ward kitchen and in each sluice area.

This action was satisfactorily completed. Hand-washing facilities have been installed in unit kitchenettes and sluices. Unit kitchenettes and sluices have been refurbished with to a good standard with stainless steel units.

8. Action required from previous inspection:
The accommodation provided for residents was mainly in multi-occupancy rooms and there was insufficient personal space to meet the needs of residents and current standards.

Provide appropriate personal space for all residents throughout the centre. As there is a six year time span allowed to do this provide a programme of actions that will outline how the requirements with be met within this time frame.

This action was partially completed. Inspectors viewed documentary evidence that resident numbers had been reduced to achieve a net effect of reducing five bedded accommodation down to rooms with accommodation for four residents. However, in practice when a bed was vacated by a current resident's admission to hospital or going on leave, another short stay resident was admitted during this time. Rooms with four beds were increased to five beds to accommodate the short-stay admissions. This resulted in long term residents not being able to enjoy the increased space achieved by reduced beds in their rooms on a permanent basis.

One unit has been completely refurbished to a good structural standard. However, seven four-bedded rooms are located in this unit which will meet *the National Quality Standards for Residential Care Settings for Older People in Ireland*, if high dependency residents in need of 24 hour high support nursing care are required. Inspectors were told that plans were in place to refurbish the remaining three units. Efforts have been made to increase residents' personal space by reducing multioccupancy rooms to four beds. This action is restated in the action plan at the end of this report.

9. Action required from previous inspection:
The residents' records were not being maintained in accordance with current legislation in that residents' PPS numbers had not been recorded for all residents. The loose leaf folder format for the directory of residents did not provide appropriate levels of security

The registered provider shall maintain all the required records for each resident in accordance with Schedule 3.

This action was partially completed. The directory was bound and pages were secure. However, the required resident information was not in place, for example a record was not made in the directory of occasions when a resident was not in the centre due to hospital admission or on leave. This action is restated in the action plan at the end of this report.

10. Action required from previous inspection:
Inspectors noted that there were 10 vacant nursing posts and no replacements had been provided.

The provider must outline how this deficit is being managed and how the skill mix of staff is being determined to ensure the safety and well being of residents.

This action was not satisfactorily completed. There was no link between resident dependencies, staffing levels and skill mix in meeting the needs of current residents and new admissions. Dependency levels were measured using a recognised tool by the occupational therapist. Residents' dependency levels were not routinely measured or used to for managing staffing levels and skill mix in response to residents' changing needs and unplanned leave.

Inspectors were informed that residents were admitted in the evening. Inspectors observed a resident transferred to the centre from the acute hospital on the evening of the inspection. While residents could not be reviewed by the medical officer until the day following admission, staffing levels were also reduced in the evenings.

There was evidence that beds designated for residents with rehabilitation needs were being used for accommodating long stay and respite admissions. This practice increased long-stay and respite resident numbers without increasing staffing levels or skill mix. While agency staff were utilised, the same nurse was contracted consistently. Staff leave was only replaced for 31 hours per week. On the day of inspection there were fifteen staff members on sick leave. There was evidence that staff annual leave was cancelled to cover sick leave on one unit.

Inspectors viewed the staffing rotas for a two week period and found that on night duty staffing levels were reduced to two staff for three units even though resident numbers with maximum and high dependency level needs varied from eleven to nineteen. Our Lady's dementia care unit which accommodated twenty residents also had two staff rostered for night duty. A review of incidents on one unit from 03 August to the 03 October 2010 referenced that 100% (14) of resident falls were not witnessed by a staff member. Approximately 71% (10) of which occurred between 18:00 hrs and 06:00 hrs. There was also evidence that residents were not afforded choice of bath or shower every day. One resident was facilitated to have a shower once per week, while they had a bed bath each other day due to staff shortages. However, a shower trolley was available. Another resident did not like showers but enjoyed a bath; she was assisted to have a bath before Christmas 2010. A staff member confirmed that staffing levels and skill mix directly impacted on care provision. This action is restated in the action plan at the end of this report.

11. Action required from previous inspection:
There were inadequate systems for the storage of equipment and inadequate storage for a reasonable amount of personal belongings for residents.

The provider must make available adequate storage for equipment and for residents' personal belongings.

This action was partially completed. Storage facility for residents' equipment and personal belongings was not adequate in three units. Although efforts were made to personalise some residents' bed spaces, there was inadequate space for hoists, linen trolleys and skips. Linen cupboards were utilised for storage of equipment, while this was inappropriate storage, these cupboards were inaccessible and posed a risk of injury to those accessing them. Floor space where beds had been reduced in multioccupancy rooms was also utilised for storage purposes, cancelling any space gain by residents by

this action. Inspectors noted one resident had a small personal fridge yet this was located on top of a wardrobe. A risk assessment had not been completed to evaluate the safety of this location.

There was no evidence to support that the adequacy of residents' storage for personal belongings was assessed for each resident. This action is restated in the action plan at the end of this report.

12. Action required from previous inspection:
There was inadequate ventilation in toilets, bathrooms and sluice areas and in the smoking area.

The provider must ensure that there is adequate ventilation in toilets, bathrooms and sluice.

This action was partially completed. Residents, toilets and shower/bathrooms and sluices in three units viewed by inspectors did not have adequate ventilation. The shower in one unit could only be ventilated to the external air by opening a window which was at a level where the residents' privacy could be severely compromised while carrying out personal care. The smoking room in St Catherine's unit was permanently ventilated to the external air. This action is restated in the action plan at the end of this report.

13. Action required from previous inspection:
The procedure for the receipt and transcribing of medication was not fully documented.

The provider shall ensure that appropriate and suitable practices and operational policies relating to the receipt and transcribing of medication are available in the centre.

This action was not satisfactorily completed. Although a policy was in place referencing medication transcription, this was not reflected in practice. Not all medication prescription sheets were signed by the person who transcribed them. Medication prescriptions were transcribed in typed format. However, many of them also had additional hand written drugs prescribed. Schedule two controlled medication were transcribed for example morphine sulphate tablets (MST) did not meet the prescribing standards for schedule two medications as required by the Misuse of Drugs (Safe Custody) Regulations, 1982. This action is restated in the action plan at the end of this report.

14. Action required from previous inspection:
Contracts of care with the residents were not available at the centre.

A contract shall be agreed with each resident detailing the services to be provided for and the fees to be charged.

This action was partially completed. New resident contracts reflect fair deal arrangements. All residents or next of kin have not signed in agreement of new contracts. This action is restated in the action plan at the end of this report.

Recommendations

Standard	Best practice recommendations
Standard 19: Meals and Mealtimes	Meals are served plated to the table. Consultation should take place with residents to determine if they would like to be able to help themselves to vegetables at the table. **Providers Response** None entered by Provider. **Inspection Findings** This recommendation was not completed. Meals were served plated on the day of the inspection. This recommendation has been restated.
	The arrangements in place at lunch time throughout the centre should be reviewed to make mealtimes a less hasty and rushed experience for residents. **Providers Response** None entered by Provider **Inspection Findings** This recommendation was not completed. Inspectors observed urgency with getting meals served to residents.
Standard 23: Staffing Levels	The long term implications of the public service embargo must be regularly reviewed and a strategy put in place to ensure an appropriate skill mix to meet the needs of residents. **Providers Response:** None entered by Provider **Inspection Findings:** This recommendation was not completed. Staffing levels were not reflective of dependency needs of the residents. This recommendation has been restated.
Standard 29 Management systems	Policies and procedures to meet the statutory requirements have been compiled. Systems must now be put in place to convey this information to residents and staff. **Providers Response:** None entered by Provider

	Inspection findings An assistant director of nursing had assigned responsibility for developing policies and procedures for the centre. While the medication management policy was not adequate in all areas, the restraint management policy was of a good standard but not reflected in all areas of practice. Although these policies and procedures have been completed they have not been implemented. This recommendation has been restated.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the person in charge, assistant directors of nursing, clinical nurse managers and staff nurses to report on the inspectors' findings, which highlighted both good practice and where significant improvements were needed.

Acknowledgements

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection

Report compiled by:

Catherine Connolly-Gargan
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

04 January 2011

Chronology of previous HIQA inspections	
Date of previous inspection	**Type of inspection:**
28 and 29 September 2009	☐ Registration ☒ Scheduled ☐ Follow up inspection ☒ Announced ☐ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to additional inspection report[*]

Centre:	Sacred Heart Hospital
Centre ID:	0654
Date of inspection:	04 January 2011
Date of response:	14 March 2011

Requirements

These requirements set out what the registered provider must do to meet the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

1. The person in charge has failed to comply with a regulatory requirement in the following respect:

There were no cleaning /domestic staff in some units while in others, they were not available after 14:00 hrs. This compromised infection control arrangements and diverted care and nursing staff from their specific roles and responsibilities.

Staffing levels and skill mix did not adequately meet the assessed needs of all residents given the size and layout of the centre at all times of the day and night in each unit.

Action required:

The provider shall ensure that at all times the numbers and skill mix of all grades of staff are appropriate to the assessed needs of residents and the size and layout of the designated centre.

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

Action required: Put arrangements in place where the dependency levels of each resident is regularly reviewed to reflect their changing needs and assistance.	
Action required: Provide sufficient staff to maintain the centre in a clean and hygienic state.	
Reference: Health Act, 2007 Regulation 16: Staffing Standard 23: Staffing Levels and Qualifications	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
▪ We are currently reviewing our roster, taking into account skill mix available and our resident daily dependency levels.	31 March 2011
▪ We have employed contract cleaners for a deep clean of the unit and the unit is being maintained in a clean and hygienic state. This deep clean process will be completed 14 March 2011. We are currently reviewing our cleaning rosters with staff and exploring other long term arrangements.	31 March 2011
▪ Dependency levels are being carried out daily and being monitored by nursing administration.	Complete
▪ Deep clean has arranged for week commencing 07 February 2011.	14 March 2011

2. The Person in Charge has failed to comply with a regulatory requirement in the following respect:

The social care needs of residents were not consistently described in care records. In particular the social care of residents who are very frail or who had memory problems were not adequately identified or addressed.

Action required;

The provider must have in place a system to identify the social care needs of all residents including those who are very frail or who have memory problems and provide recreation and relaxation opportunities.

Action required;

Facilitate training for all staff on care planning.

Reference:

Health Act, 2007
Regulation 8: Assessment and Care Plan
Standard 11: The Resident's Care Plan

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: ▪ We are currently introducing a social care plan, for each resident, which has commenced with residents who are very frail and have memory problems. From our social care assessment we will design an individual activity programme. ▪ We have liaised with the Nurse Planning and Midwifery Unit for training on care planning. Training dates are 3 March, 7 March and 16 March 2011.	31 April 2011 30 April 2011

3. The provider has failed to comply with a regulatory requirement in the following respect:

Hot tap water temperatures were not monitored to ensure residents were not placed at risk of scald injury.

Ensure that the size and layout of multioccupancy rooms are adequate so that residents have adequate private and communal accommodation.

All parts of the centre were not clean.

Suitable provision for storage of equipment was not in place.

Ventilation to the external air was not adequate in a toilets, sluices, bathrooms and showers.

Grab rails were not in place on both sides of toilets and showers.

Residents were unable to reach light switches or able to operate the electronic water dispensers.

A shower was not provided in the staff changing facilities.

Action required:

Ensure that monitoring procedures are put in place to prevent scald injury to residents.

Action required: Having regard for the numbers and needs of residents ensure that there is adequate private and communal space provided for residents.	
Action required: Provide suitable storage facilities for equipment to minimise risk of injury to residents or others.	
Action required: Put procedures in place to maintain the centre in a clean and hygienic state at all times.	
Action required: Provide adequate permanent ventilation to the external air in toilets, bathrooms, showers and sluices.	
Action required: Provide adequate staff changing facilities.	
Action required: Provide grab rails on both sides of toilets used by residents.	
Action required: Ensure all resident equipment is adequate to meet the needs of residents to include lighting and water dispensers.	
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response: ▪ External experts have monitored all water delivery and found same with appropriate temperature range. We liaised with our maintenance team who are implementing checks to monitor water temperatures and will insure documentation is available for inspection.	7 March 2011 21 February 2011

- Liaising with HSE Technical Services and local maintenance manager re private and communal space to comply with the Standards. The practice of putting in additional beds on a temporary basis has ceased. Also, communal areas are not being used for storage. HSE maintenance, DON and technique service are assessing all areas on April 5 2011 and the information gathered from this will be used to provide a plan going forward re communal space and storage. - Storage space in the unit is currently under review with technical services and maintenance manager. This is being reviewed by maintenance, director of nursing and technical services on April 5 2011 and a plan will then be put in place.	31 July 201
- Cleaning schedules have been updated and regular audits of same will be carried out and documented.	31 March 2011
- Re external ventilation of sluices, same accessed by maintenance manager, costing been drawn up, approval sought to proceed.	30 April 2011
- Shower facilities available for staff, lighting now fixed.	03 February 2011
- Assessment of all toilets completed by occupational therapist and maintenance manager is arranging for fixture of same.	03 February 2011
- Review water dispenser and lighting accessibility to be completed by nurse manager, occupational therapist and maintenance. For residents that could not access water from dispenser we are providing jugs and glasses in all areas. Risk assessment is being carried out on accessing to lighting in toilet area; from this a plan will be put in place.	31 March 2011

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

The residents' records were not being maintained in accordance with current legislation in that a record was not maintained of each time a restraint was used, the nature of the restraint and its duration. Records were not kept in a secure and accessible way. Medication errors or adverse reactions were not recorded.

Action required:

The provider shall maintain all the required records for each resident in a way that ensures they are secure and easily accessible.

Action required: Records must be maintained for restraint use, type and duration for each resident.	
Action required: Maintain records of any medication error or adverse reactions in relation to each resident.	
Reference: Health Act 2007 Regulation 22: Maintenance of Records Regulation 25: Medical Records Standard 32: Register and Residents' Records	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
▪ A review of storage of residents records is currently been undertaken by service manager. Current resident's medical records will be stored in a locked filing cabinet.	31 May 2011
▪ Implement a resident risk assessment for the use of restraint and develop individual care plan to support this.	31 March 2011
▪ We will introduce a recording sheet for where restraint is used, the nature of restraint and its duration.	31 March 2011
▪ Records will be maintained on medication error or adverse reactions in relation to each resident. A desktop review of incidences/errors will be carried out quarterly at the local health and safety meetings.	31 March 2011

5. The Provider and Person in Charge has failed has failed to comply with a regulatory requirement in the following respect:

Residents were subject to restraint measures such as bedrails, lap belts and chairs with tables fixed in front of them without adequate evidence avail-able of comprehensive assessment of need and that exploration of alternatives to these restraint measures were considered.

Opportunities were not provided for each resident including those with physical, cognitive or sensory disability to participate in a programme of activities appropriate to their interests and capabilities.

Action required: Ensure provision of suitable and sufficient care to maintain the resident's welfare and wellbeing in relation to restraints, taking into consideration the nature and extent of the resident's dependency and needs.	
Action required: Ensure that residents' care is based on a high standard of evidence-based nursing practice, and that the use of restraint measures and pressure area care reflects this.	
Action required: The activities program in the centre requires development so that each resident including those with physical, cognitive or sensory disability are afforded ample opportunity for participation in purposeful and meaningful activity.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 13: Healthcare Standard 18: Routines and Expectations	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: ▪ The HSE has developed a national policy on restraint. The Sacred Heart Hospital will adapt this and fully co-operate with the implementation of same following proposed training from the H.S.E. In the interim, documentation will be developed to an assessment and recording for use of any restraint. It will include documented assessment of need with aim of minimal restraint, consent, documented arrangements for monitoring, frequency of release and inspection and care of skin. A review of current equipment has been carried out, costing complete to facility minimizing restraint, awaiting approval for purchase. ▪ Care planning and assessment currently being developed with NPMDU – training for care planning is taken place on 3, 9 and 16 March. New documentation is being rolled out following same. We will document assessment of need with aim of minimal restraint, consent, document arrangements for monitoring, frequency of release and inspection and care of skin. Rollout of new care plan will be completed by 31 May 2011. 30 nursing staff will have completed training in care planning on 16 March 2011. Restraint documentation will be in place 31 March 2011	31 March 2011 Rollout of new care plan will be completed by 31 May 2011. 30 Nursing staff will have completed training in care planning on 16 March 2011.Restraint documentation will be in place 31 March 2011

▪ We are currently introducing a social care plan, for each resident. From our social care assessment we will design an individual activity program. Developing a social activity area.	30 April 2011

6. The Provider is failing to comply with a regulatory requirement in the following respect: All staff did not routinely participate in regular fire drills. Instructions to be followed in the event of a fire including plans showing evacuation routes were not available throughout the centre and instructions were not provided in a format accessible to all residents. Fire exit signage was not adequate to locate fire exit doors from all parts of the building. Evacuation risk assessments had not been completed for each resident including the feasibility or safety of procedures in place for blanket evacuation of dependent residents.
Action required: Ensure unobstructed exit from the building through designated fire exits at all times of the day and night if necessary and initiate a checking procedure to ensure that all designated fire exits are available.
Action required: Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.
Action required: Make adequate arrangements (including staffing and equipment) for the evacuation, to safety in the event of fire, of all people in the designated centre.
Action required: Evaluate the adequacy of emergency lighting and fire exit directional signage in the centre to assist with safe evacuation.
Action required: Develop fire escape plans to clearly show the escape route and locate plans at strategic points around the building.

Action required:

Submit written confirmation from a competent person that all the requirements of the statutory fire authority have being complied using the Authority's document.

Reference:

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

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
▪ We have put a checking procedure in place to ensure that designated fire exits remain unobstructed for nominated staff during the day and night times.	04 February 2011
▪ Evacuation procedures are been addressed during training that has taken place on Monday 31 January 2011 and will be included in future training. Further training took place on March 2 2011. Residents have also attended fire drills since inspection. All staff on duty will have completed fire training and drill on 10 March 2011 with exception to those on leaves.	04 February 2011
▪ Recommendation from HTM 05-02 section 3.21 and 3.22 are being reviewed to ensure compliance with same. See previous point relating to evacuation procedure.	31 March 2011
▪ The Estates office is reviewing emergency lighting/signage with a view to devising a plan for same. Fire signage has been changed to a maintained system throughout the centre. All light have been reviewed. Estates are going to complete a full review on April 5 2011. Technical services are reviewing emergency lighting and signage on 5 April 2011 and from this a plan will be drawn up.	30 May 2011
▪ The Maintenance department will be forwarding drawing of the Sacred Heart Hospital to the Estates office for review.	31 March 2011
▪ The Estates office will be submitting written submission regarding compliance with fire safety legislation and associated standards. The intention is to endeavour to have this completed for registration of the site.	31 March 2011

7. The provider is failing to comply with a regulatory requirement in the following respect: The content of the Statement of Purpose did not meet the legislative requirements.	
Action required: Compile a Statement of purpose that consists of all matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).	
Action required: Make a copy of the revised Statement of Purpose available to the Chief Inspector of Social Services.	
Reference: Health Act, 2007 Regulation 5: Statement of Purpose Standard 28: Purpose and Function	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Revised Statement of Purpose will be forwarded to the Health and Information Quality Authority.	28 February 2011

8. The provider is failing to comply with a regulatory requirement in the following respect: There was no system to monitor the quality and safety of care provided to and the quality of life of, residents in the designated centre at appropriate intervals.
Action required: Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.
Action required: Conduct audit on care plans, medication practice, complaints and hygiene.
Reference: Health Act, 2007 Regulation 35: Review of Quality and Safety of Care and Quality of Life Standard 30: Quality Assurance and Continuous Improvement

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: We are arranging for regular audits to take place on care planning, medication practice, pressure area care, complaints, incidents and hygiene. A system will be future developed to review the quality and safety of care provided to our residents as per Standard 30. We have carried out audit on care plans pressure area care and are implementing the findings We are monitoring and documenting weekly, residents who have pressure sores, restraints, psychotropic drug administration, indwelling catheters, those who have had a fall, experienced severe pain, weight loss, those who spend most of their time in a chair and any other significant events.	 31 March 2011 31 March 2011

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

All procedures and equipment were not in place to effectively manage risk to residents in the centre.

There were no arrangements in place for the identification and learning from serious or untoward incidents or adverse events involving residents.

Action required:

Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified. For example those associated with accessibility of kitchenette facilities to vulnerable residents and security arrangements to minimise ingestion risk.

Action required:

Provide safe floor covering in all areas of the centre.

Action required:

Put in place arrangements in place for the identification and learning from serious or untoward incidents or adverse events involving residents.

Reference:

Health Act, 2007
Regulation 31: Risk Management Procedures
Standard 26: Health and Safety
Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
▪ We have carried out risk assessments of ward kitchenettes and revised access to residents.	15 April 2011
▪ The process for identifying and assessing risk in all areas is being reviewed.	15 April 2011
▪ Maintenance manager has completed an assessment of all floor areas and unsafe floor covering will be replaced. Completion date for this is 15 April 2011.	15 April 2011
▪ A process is being devised for reviewing all incidents. The information received will be discussed at the Health and Safety meeting. Learning from same will be implemented. Minutes will be available for all staff.	15 April 2011

10.The Person in Charge is failing to comply with a regulatory requirement in the following respect: Staff had not been trained in relation to communicating with people with dementia and working with challenging behaviour. Household staff were not supervised on an appropriate basis pertinent to their role.
Action required: Assess the individual training needs of staff and implement a suitable plan of training particularly in relation to communicating with people with dementia and working with challenging behaviour.
Action required: Conduct a training needs analysis to take into account the nature, diagnosis, dependencies and treatments provided to ensure that training is specific to the current needs of the residents.
Action required: Put arrangements in place to ensure all cleaning staff are supervised on an appropriate basis pertinent to their role.

Reference:

Health Act, 2007
Regulation 17: Training and Staff Development
Standard 24: Training and Supervision

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
▪ We will conduct a training needs analysis for all grades of staff and match future training to the current needs of our residents.	31 May 2011
▪ Our speech and language therapist has commenced communication training with staff working with very frail residents with memory impairment. Additional challenging behaviour and dementia training is arranged for February and March.	31 March 2011
▪ Audit of cleaning is being devised; we have employed contract cleaners for a deep clean of the unit and the unit is being maintained in a clean and hygienic state. This deep clean process will be completed 14 March 2011. We are currently reviewing our cleaning rosters with staff and exploring other long term arrangements.	31 March 2011

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

Medication storage, prescribing and administration were not in line with legislative and professional standards.

Action required:

Ensure that there are appropriate and suitable practices relating to the prescribing, storage and administration of PRN (as required) medications and controlled drug medication.

Action required:

Redraft the centres medication management policy to reference all areas of medication management in the centre.

Action required:

Evaluate the appropriateness of the pharmacy and dispensing arrangements in place in the centre.

Action required:

Revise medication transcribing practices in the centre to reflect evidence-based best practice in accordance with guidelines and legislative procedures.

Reference:

Health Act, 2007
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response:	
▪ We are reviewing our practices of prescribing, storage and administration of PRN medication and controlled drug medication.	30 April 2011
▪ The medication management policy will be reviewed to reference all areas of medication management in the centre.	30 April 2011
▪ We are currently reviewing pharmacy and dispensing arrangements.	30 April 2011
▪ We are revising transcribing practice in the centre Risk assessment will be carried out and risk minimised.	30 April 2011
▪ 10 Nursing staff have complete medication management training since the inspection.	30 April 2011

12.The person in charge has failed to comply with a regulatory requirement in the following respect:

Did not provide the Chief Inspector of Social Services with;

Notification of all incidents and accidents where a resident sustained an injury in the centre.

Notification of two incidents of alleged elder abuse.

Notification of a pressure ulcer - grade two or above

Action required: Notify the Chief Inspector of Social Services of incidents as required by the Health Act (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).	
Reference: Health Act, 2007 Regulation 36: Notification of Incidents Standard 30: Quality Assurance and Continuous Improvement	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Steps are being put in place to notify the Chief Inspector of Social Services as per Regulation 36 on a quarterly basis. January 2011 data has been forwarded.	01 February 2011

13. The provider is failing to comply with a regulatory requirement in the following respect: All complaints were not logged appropriately. A record was not maintained for all complaints. Complainant's satisfaction with outcomes of complaints made was not sought in all cases.
Action required: Revise the complaints procedure to ensure that complaints are logged appropriately and comply with current legislation.
Action required: Ensure that an accurate record is maintained of all complaints in a designated complaints log.
Action required: Put procedures in place to obtain complainants satisfaction regarding outcomes of all complaints.

Action required: Revised complaints procedure must be added to the Statement of Purpose.	
Reference: Health Act, 2007 Regulation 39: Complaints Procedure Standard 6: Complaints	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: ▪ The complaints procedure is being revised to ensure that complaints are logged appropriately and comply with current legislation. ▪ A system is now in place to ensure that all complaints will be recorded accurately. ▪ The complaints procedure will include the complainant's satisfaction regarding outcome of the complaint. ▪ The revised complaints procedure will be added to the Statement of Purpose when completed.	 03 February 2011 03 February 2011 01 March 2011 01 March 2011

14. The person in charge has failed to comply with a regulatory requirement in the following respect: The directory of residents was not up to date and did not contain details of a resident who had gone to hospital.	
Action required: Ensure the directory of residents is kept up to date and references all residents in the centre as outlined in the legislation.	
Reference: Health Act, 2007 Regulation 23: Directory of Residents Standard 32: Register and Residents' Records	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response:	
A new residents' directory has been ordered and this will be kept up to date and reference all residents in the centre as outlined in the legislation. This information was previously recorded on our IT system.	28 February 2011

15. The Provider and Person in Charge is failing to comply with a regulatory requirement in the following respect:

The lay-out and signage of Our Lady's dementia care unit did not adequately meet the needs of residents with dementia and cognitive impairment as all doors were the same, signage was inadequate and communication aids to encourage and assist all residents to communicate were not in place.

Action required:

Evaluate the lay-out and signage in all areas of the centre including Our Lady's dementia care unit to ensure it adequately meets the communication needs of residents with dementia and cognitive impairment. Put a programme in place to address deficits that adheres to evidence-based principles for care of residents with dementia or cognitive disabilities.

Action required:

Put procedures in place where each resident is facilitated and encouraged to communicate.

Reference:

Health Act, 2007
Regulation 11: Communication
Regulation 19: Premises
Standard 25: Physical Environment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
▪ A review of the layout and signage of all areas is currently being undertaken by director of nursing and maintenance manager, with assistance from dementia centre, St James Hospital. CNM and director of nursing (DON) have visited the dementia unit in St James Hospital. The DON has also attended the three day dementia design programme.	Completion date 31 May 2011
▪ Director of nursing is liaising with the speech and language therapist around devising a system that ensures and	30 June 2011

encourages all residents to communicate. Further training facilitated by the speech and language therapist to take place.	
▪ An assessment of communication aids required will be carried out by speech and language therapist.	31 March 2011
▪ Commencement of an advocacy service for residents – we have five nominated advocates who are currently completing the FETAC course in advocacy.	03 February 2011

16. The Provider has failed to comply with a regulatory requirement in the following respect:

Residents who are unable to attend the acute hospital do not have access to a dietician.

Action required:

Put arrangements in place where all appropriate health care is facilitated including access to dietetic services.

Reference:

Health Act, 2007
Regulation 9: Health Care
Standard 13: Healthcare

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response:	
A further risk assessment has been completed re the benefits and positive health outcomes of having a dietetic service. Discussions to take place with the Director of Nursing and Local Health Manager regarding this issue. Discussions are ongoing and exploring all options open to us to provide a dietetic service to our residents.	28 February 2011
An interim plan of reviewing residents at risk nutritionally who are unable to attend the acute hospital will be put in place. Eight Residents identified at risk have been seen by a dietician.	28 February 2011

17. The Provider has failed to comply with a regulatory requirement in the following respect:

All residents did not have signed contracts of care.

Action required: Put arrangements in place where all residents are provided with contracts of care and that they or their next of kin sign in agreement.	
Reference: Health Act, 2007 Regulation 28: Contract for the Provision of Services Standard 7: Contract/Statement of Terms and Conditions	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Arrangements are being put in place to ensure that all residents are provided with contracts of care and they or their next of kin sign in agreement. We have got our contract of care reviewed by legal advice.	31 March 2011

Recommendations

These recommendations are taken from the best practice described in the *National Quality Standards for Residential Care Settings for Older People in Ireland* and the registered provider should consider them as a way of improving the service.

Standard	**Best practice recommendations**
Standard 25: Physical Environment	Provide cleaning room facilities that meet the requirements set out in *the National Quality Standards for Residential Care Settings for Older People in Ireland*. **Providers Response:** Cleaning room facilities are currently being updated. Sinks and backing have been ordered. Completion date: 30 April 2011
Standard 18: Routines and Expectations	Display a schedule of recreational activities to facilitate residents who are able to make choices about which activity they attend. **Providers Response:** A schedule of recreational activities will be displayed in each ward area. White boards have been ordered. And these will be updated regularly. Completion date: 31 March 2011
Standard 19 Meals and Mealtimes	Meals are served plated to the table. Consultation should take place with residents to determine if they would like to be able to help themselves to vegetables at the table. **Providers Response:** Arrangements are being put in place for advocates to dine and consult with residents at mealtimes re their mealtime experience. From this all suggestions, outcomes, satisfaction and changes will be documented and plans will be put in place to implement. Completion date: 30 April 2011.
	The arrangements in place at lunch time throughout the centre should be reviewed to make mealtimes a less hasty and rushed experience for residents. **Providers Response:** Arrangements are being put in place for advocates to consult with residents at mealtimes re their mealtime experience. From this all suggestions, outcomes, satisfaction and changes will be documented and plans will be put in place to implement. An additional dining room is planned so residents will have a further

	choice of meal times. Completion date: 30 April 2011
Standard 23 Staffing Levels	The long term implications of the public service embargo must be regularly reviewed and a strategy put in place to ensure an appropriate skill mix to meet the needs of residents. **Providers Response:** Whilst there is no validated evidence based assessment tool available re staffing levels linked to residents needs, we are in the process of looking at other assessment tools available in the UK that will incorporate skill mix and the needs of our residents**.** Completion date: 28 February 2011
Standard 14: Medication Management	Make arrangements for medical review of medication on a three monthly basis. **Providers Response:** We have arrangements in place that medication will be reviewed three monthly. We are currently liaising with the G.P. re maintaining 3 monthly regular reviews. Completion date: 31 March 2011
Standard 26 Health and Safety.	Put a documented procedure in place to inform staff on appropriate changing of masks and nebuliser cleaning procedures that are in line with infection control and standards on legionella prevention and control in Ireland. **Providers Response:** We are currently seeking advice from infection control specialist and will implement best practice. Completion date: 31 March 2011
Standard 13: Healthcare	Put arrangements in place where residents are provided with a choice of general practitioner (GP). **Providers Response:** Discussions are taken place with GP, Service Manager and Director of Nursing around how best we can provide a service of choice. 30 April 2011 for decision
Standard 4: Privacy and Dignity	Ensure residents' personal information is not displayed. **Provider Response:** Residents' personal information is no longer displayed. Completion date: 3 February 2011
Standard 10: Assessment	Review admission process to ensure residents are admitted early in the day to facilitate adequate assessment. **Provider Response:** Admission procedures are currently being reviewed at the Sacred

	Heart Hospital to ensure that all new admissions to the centre will take place prior to 4pm. Completion date: 18 February 2011

Any comments the provider may wish to make:

Provider's response:

The team at the Sacred Heart Hospital were pleased to note from the report that residents interviewed were complimentary of the service provided, spoke highly of the staff , confirmed the were satisfied with the service provided, were aware how to make a complaint and had no complaints at current time.

The significant positive development of St Catherine's and three palliative care rooms was noted to have improved the quality of life and environment for residents, with the introduction of relaxation areas and restful spaces. We are working towards updating the remainder two units under the capital development plan to include a 50-bedded single room accommodation and a dementia specific unit.

What we have learned as a team is how important it is to document what you are actually doing. While the team found the inspection process difficult the most important issue now is to implement its findings.

Provider's name: Frank Murphy
Date: 04 February 2011