Health Information and Quality Authority
Social Services Inspectorate

Registration Inspection report
Designated Centres under Health Act 2007

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

Centre name:	Sacred Hearts Hospital
Centre ID:	0654
Centre address:	Golf Links Road Roscommon Co. Roscommon
Telephone number:	090-6626130
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Email address:	Julie.silke@hse.ie
Type of centre:	☐ **Private** ☐ **Voluntary** ☒ **Public**
Registered provider:	Health Services Executive
Person authorised to act on behalf of the provider:	Catherine Cunningham
Person in charge:	Julie Silke Daly
Date of inspection:	11, 12 and 13 October 2011
Time inspection took place:	Day 1 Start:10:30 hrs **Completion:** 18:15 hrs Day 2 Start:08:40 hrs **Completion:** 18:00 hrs Day 3 Start:07:50 hrs **Completion:** 16:15 hrs
Lead inspector:	Geraldine Jolley
Support inspector(s):	Bríd McGoldrick and Damien Woods (Day 1)
Type of inspection:	☒ **Registration** ☒ **Announced** ☐ **Unannounced**

About registration

The purpose of regulation is to protect vulnerable people of any age who are receiving residential care services. Regulation gives confidence to the public that people receiving care and support in a designated centre are receiving a good, safe, service. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected.

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

Under section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.

As part of the registration process, the provider must satisfy the Chief Inspector that s/he is fit to provide the service and that the service is in compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2009 (as amended).

In regulating entry into service provision, the Authority is fulfilling an important duty under section 41 of the Health Act 2007. Part of this regulatory duty is a statutory discretion to refuse registration if the Authority is not satisfied about a provider's fitness to provide services, or the fitness of any other person involved in the management of a centre. The registration process confirms publicly and openly that registered providers are, in the terminology of the law, "fit persons" and are legally permitted to provide that service.

Other elements of the process designed to assess the provider's fitness include, but are not limited to: the information provided in the application to register, the Fit Person self-assessment, the Fit Person interviews, findings from previous inspections and the provider's capacity to implement any actions as a result of inspection.

Following the assessment of these elements, a recommendation will be made by inspectors to the Chief Inspector. Therefore, at the time of writing this report, a decision has not yet been made in relation to the registration of the named service.

The findings of the registration inspection are set out under eighteen outcome statements. These outcomes set out what is expected in designated centres and are based on the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended); the *National Quality Standards for Residential Care Settings for Older People in Ireland*. Resident's comments are found throughout the report.

The registration inspection report is available to residents, relatives, providers and members of the public, and is published on www.hiqa.ie in keeping with the Authority's values of openness and transparency.

About the centre

Location of centre and description of services and premises

The Sacred Heart Hospital is operated by the Health Service Executive and is located on Golf Links road, a short drive from the shops and business premises of Roscommon Town. The centre is set in a spacious site of five acres which is mostly cultivated to lawn and garden. There are car parking spaces to the front and side of the building.

The centre provides continuing care, rehabilitation, palliative and respite care for up to 95 residents from Roscommon and the surrounding area. Part of the building dates from 1842 and it has been converted and modified over the years to improve the facilities available for residents. It comprises of four units - St. Catherine's, St. Joseph's, St. Michael's and Our Lady's. St. Catherine's was extensively refurbished during 2009/2010 and now accommodates 37 residents. There are 22 long term care places here and the remaining places are allocated for rehabilitation or respite care. Appropriate communal dining and sitting space for residents as well as good office, catering and staff facilities had been provided.

Our Lady's unit was redecorated and reorganised earlier this year and now accommodates twenty residents some of whom have dementia care problems. The newly refurbished areas provided attractive environments and were well decorated with coordinated soft furnishings.

St. Josephs and St. Michael's units have capacity for 25 residents each. All units have their own communal space, bathrooms, toilets and sluice facilities. Residents' bedroom areas are predominantly multiple occupancy rooms of four beds.
St. Catherine's has two double rooms and there is a single room available in three units that are mainly used for residents at end of life or who have palliative care needs.

A day care service that accommodates up to 25 people daily is also available on site. The rehabilitation and respite services were used extensively. The occupational and physiotherapy area was strategically located near the entrance and the inspectors noted that this was well equipped and in regular use. The other facilities include a church, several sitting areas, a relaxation room and the main catering kitchen and laundry areas.

The centre has a safe and secure garden area to the rear and there were plans to redesign this area being considered by staff and residents.

Date centre was first established:	1842
Number of residents on the date of inspection:	73
Number of vacancies on the date of inspection:	22

Dependency level of current residents as provided by the centre:	Max	High	Medium	Low
Number of residents	23	32	11	7
Gender of residents			Male (✓)	Female (✓)
			24	49

Management structure

The Person in Charge, Julie Silke-Daly reports to the HSE General Manager for the area, Catherine Cunningham 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 and administrative, clerical and ancillary staff. A multidisciplinary team of physiotherapists and occupational therapists and a medical officer complete the staff profile.

Summary of compliance with 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*.

This report set out the findings of the announced registration inspection of Sacred Heart Hospital, Roscommon which took place on 11, 12 and 13 October 2011 following an application to the Health Information and Quality Authority (the Authority) for registration under Section 48 of the Health Act 2007.

This was the third inspection of the centre undertaken by the Authority. The first inspection was announced and took place on 28 and 29 September 2009. An action plan detailing fourteen areas that required improvement was forwarded to the provider and person in charge following this inspection. The main areas where improvements were required included governance, the quality of service, staffing levels and environmental matters. An unannounced follow-up inspection was conducted on 4 January 2011 to review the response to the action plan. The inspectors found that few actions had been satisfactorily completed and identified a range of other matters that needed attention. These included medication management practices, risk management including fire safety, improvements to care documentation, restraint practices and general decoration and furnishing of the building. There was also a requirement to improve the facilities for residents with dementia in Our Lady's unit. In particular the uneven floor was identified as a hazard and there was poor signage to guide and prompt residents to facilities in the unit.

During this registration inspection, inspectors found that there had been significant efforts made to address the action plan comprehensively. This finding is illustrated by the changes that had taken place. The person in charge and her staff team told inspectors that they had worked together to address the action plan and to improve the facilities and healthcare practice. Among the main changes were:

- cleaning staff were now available throughout the working day instead of finishing their duties at lunch time and the standard of hygiene had improved,
- the medication administration system had been changed and safer procedures were in place
- redecoration and reorganization in all units including the provision of more personal space for residents had significantly improved the environment and quality of life experience for residents
- thermostatic valves on hot water outlets were working effectively ensuring that hot water was dispersed at a safe temperature.

Inspectors met with residents, relatives and staff members over the three day inspection. Inspectors observed day to day care practice and reviewed documentation such as care plans, medical records, accident records, policies and procedures and staff files. Separate fit person interviews were carried out with the provider and the person in charge. The Fit Person self-assessment document had been completed in advance of the inspection. This was reviewed by inspectors, along with the information provided in the registration application and supporting documentation.

Since completing the fit person entry programme a number of changes had been introduced including an update of the statement of purpose, improvements to the facilities available in particular in Our Lady's unit and better provision of meaningful activities. The person in charge gave an informed account of her responsibilities in accordance with legislation and had made arrangements to ensure that all staff were aware of the legislative process by ensuring that information on the standards and regulations were provided and discussed with staff. The provider was also well informed about her legal responsibilities and areas of legislation that applied to the nominated provider. She had had been instrumental in providing resources to carry out essential works and was familiar with the centre and the services provided.

Overall, inspectors found evidence of good practice in many areas and a commitment by the centre's management team to continually work to improve the quality of service that residents received. The health needs of residents were assessed and reviewed regularly and care practice was generally documented well in care records. There had been improvements for residents who had dementia care needs with more detail on communication and memory problems evident in care records. The inspectors did identify some improvements that were required and these included better identification and management of wound care problems, better linkage between assessments and the daily records and more rigorous attention to the completion of essential documentation such as nutrition and fluid balance charts when residents were very vulnerable.

There had been an expansion of the activity programme and residents told inspectors that they now had more choices in what they did each day and had been able to go out to football matches and out shopping. Residents had access to medical services and to a range of other allied health professional services. Residents could exercise choice in their daily life and were consulted on an ongoing basis through monthly residents' meetings.

Inspectors observed staff providing care for the residents in a competent and respectful manner. Interactions between residents and staff were positive with staff taking time to talk and listen to residents when providing personal care and more informally when in conversation in communal areas. The number of residents accommodated had been reduced to 95 due to a shortfall in staff numbers consequent to absences or retirements and the requirement to provide more appropriate personal and communal space for residents.

The action plan at the end of this report identifies improvements that must be made to meet the requirements of 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*. These improvements include a need for better security arrangements for the premises, changes to the way staff are deployed over the working day, more diligent record keeping to ensure the care needs of residents are accurately documented and the need to formulate a comprehensive emergency plan for situations other than fire to assist staff in such situations.

Section 50 (1) (b) of the Health Act 2007

Compliance with 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. Statement of purpose and quality management

Outcome 1
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the statement of purpose, and the manner in which care is provided, reflect the diverse needs of residents.

References:
Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

Inspection findings

Inspectors found that the statement of purpose described the range of required information as outlined in Schedule 1 of the (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Inspectors observed that the centre had capacity to meet the needs of residents currently accommodated and nursing and care staff have a range of qualifications and experience to ensure residents' needs are met however, the inspectors identified that staff numbers throughout the working day varied considerably and the depleted staff numbers in the evening did not take into account dependency of residents or changing care needs when residents were admitted for respite care or for rehabilitation. This was confirmed by residents and relatives who talked to inspectors and was also reflected in the comments made in the resident and relative questionnaires submitted to the inspectors where concerns were expressed about the numbers of staff available particularly in the evening.

Residents who had specialist care needs such as dementia were more appropriately assessed and supported than inspectors had noted on previous inspections. Staff had been involved in dementia care training, there were improved safety features in place, the assessment process included information on communication problems and the activity programme included options that were appropriate for people with memory problems.

The provider and person in charge were aware that the statement of purpose should be kept under review and made available to residents on admission and following any changes. The number of residents to be accommodated may alter in response to changing needs, staff availability and alterations to the premises to improve the personal space available to residents the inspectors were told. The provider and person in charge agreed to review the current document to ensure that it reflected the service to be provided and to provide a copy to the Authority if changes were made.

Outcome 2

The quality of care and experience of the residents are monitored and developed on an ongoing basis.

References:
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Inspection findings

Inspectors found that aspects of care practice were reviewed and monitored on an ongoing basis. The person in charge demonstrated a commitment to the regular auditing of care practices and had a lead role in gathering and analysing data for areas such as falls, the use of bed rails, the standard of hygiene, care plans, the use of psychotropic medication and other significant aspects of practice. The inspectors reviewed a number of the audit reports. They noted that the falls management programme was showing significant benefits with almost a 50% reduction in falls being reported.

This improvement the inspectors were told by unit staff was due to better risk assessments that identified vulnerability to falls and more rigorous measures to prevent falls such as the use of low, low beds and mats placed by beds to protect residents from injury if they fell. There had also been an audit of care plans undertaken in July and the findings and recommendations had been relayed to staff so that positive changes were acknowledged and improvements needed were addressed.

The information from quality improvement initiatives were discussed at staff and management meetings and some were publicised on notice boards for residents and families to read. The results not been formulated into a report in accordance with regulation 35 – Review of the Quality and Safety of Care and Quality of Life. The person in charge and the provider had discussed this but the format that this report would take had not been finalised.

The experiences and views of residents were used to improve care practice and quality of life. There were residents' meetings held in each unit regularly and a Residents' Satisfaction Audit had been completed in August. This highlighted that residents wished to have more activities of their choice available. The findings were published in the autumn edition of the hospital newsletter which the inspectors saw on display in Our Lady's unit. Efforts to address this were ongoing and a wider range of activities including more trips out were now available according to residents and staff.

In St. Catherine's, residents were being consulted on the development of the new garden area. The inspectors received feedback forms from 42 residents and relatives. They also talked to several relatives, visitors and some people that used the rehabilitation and respite service during the inspection. Two residents described life in the centre in detail. They confirmed that they were comfortable in their surroundings, that they had choices about when to get up and go to bed and described staff as caring and "very interested in their welfare". One resident said that after years of struggling at home in a "very poor state" once he had settled in he had made "great improvements in his mental and physical health".

Outcome 3
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Inspection findings

Inspectors found evidence that complaints were viewed seriously, recorded and investigated. The service uses the Health Service Executive (HSE) policy Your Service Your Say and a local centre specific procedure to manage complaints.

The complaints policy was displayed prominently around the centre and was summarised in the residents' guide and the statement of purpose.

Residents and relatives told inspectors they felt comfortable raising concerns with the person in charge or any member of staff should the need arise. Many residents and relatives said they had never felt the need to complain.

A record of complaints was maintained in each unit. The clinical nurse managers or nurses deal with complaints in the first instance and if the matter cannot be resolved it is referred to the person in charge who has overall responsibility for managing complaints and for maintaining the complete complaints record for the service. The inspectors found that a range of matters had been dealt with including residents' complaints about breakfast being late, a concern about sedation use and inadequate call bell access. These matters were addressed and resolved. Serious matters and complaints that cannot be resolved on site were referred to the HSE complaints officer and the provider and Local Health manager were also informed.

The inspectors found that it was difficult to determine that all matters dealt with at unit level were described in the main complaint record. The process of managing complaints needed review to comply with regulation 39 Complaints Procedures. The investigations and actions undertaken to resolve some complaints were not evident in the records of complaints that were reviewed. The outcomes were not clearly described and it could not be determined if the complainant was satisfied with the outcome.

The appeals process to the HSE complaints officer was outlined. However, this needed amendment as the Chief Inspector was also identified as a resource to appeal complaints and this is not a function of the Authority. There were no timescales outlined for the acknowledgement, investigation or conclusion of complaints in the complaints procedure to ensure the complainant is informed promptly of the outcome of their complaint as required by Regulation 39 Complaints Procedures.

2. Safeguarding and safety

Outcome 4
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.

References:
Regulation 6: General Welfare and Protection
Standard 8: Protection
Standard 9: The Resident's Finances

Inspection findings

Inspectors found that measures were in place to protect residents from being harmed or suffering abuse. All staff had received training on identifying and

responding to elder abuse. The service uses the HSE policy to guide staff on the assessment, reporting and investigation of allegations of abuse. The person in charge had notified the Authority of an allegation of abuse in July 2011. This was found to be investigated and managed in accordance with the procedures in place and the matter was the subject of an ongoing review the inspectors were told.

Staff were able to tell inspectors about the prevention of elder abuse policy, explain the different categories of abuse and state what they would do if they suspected abuse. They were also aware of measures to prevent abuse and described being vigilant, having sufficient staff on duty and staff training as preventative factors. However, the inspectors found that an incident where a residents' money was missing was not considered as possible abuse and the abuse policy did not describe abuse as a notifiable event as required by regulation 36-Notification of Incidents.

Residents' finances were found to be managed appropriately in accordance with HSE procedures that provide guidance for staff who have responsibility for managing residents' accounts. The administration staff showed the inspector the procedures in place. There were audits of the system carried out by external personnel regularly. The inspector found that all transactions were recorded, the system could be readily examined and an ongoing balance for each resident's account was available. Residents had a drawer that could be locked to secure personal items and there was a safe in the administration office where valuable items could be placed for safe keeping. A record of the property that residents brought in to the centre was maintained but this was not updated as new items were acquired by residents. The inspector also noted that while items deposited for safe keeping were recorded the record was not systematic and in general the details of the items were identified on the envelope they were placed in only. There was no signature to indicate when the items had been deposited, who had left the items for safe keeping or when items were returned to residents and what items remained.

Questionnaires completed by residents and their relatives confirmed to inspectors that residents felt safe in the centre. They said that staff were readily available to them and said that they checked on them frequently although some said that at times during the evening and night staff were very busy and had a "lot to do".

Outcome 5
The health and safety of residents, visitors and staff is promoted and protected.

References:
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Inspection findings

The inspectors found that there were systems and practices in place that were targeted at promoting the health and safety of residents, visitors and staff but some areas for improvement were identified. There was a risk management policy in place and measures in place for the management of a range of risk situations. One area of risk that had been identified included a problem sending staff on essential training due to staff shortfalls. This had been addressed by the employment of agency staff. Other risk factors included the management of challenging behaviour and security around the building. Measures to address challenging behaviour and promote safety included training for staff and regular discussions with multidisciplinary team members to guide and inform staff on the most appropriate actions to take to respond to the problems presented.

The inspectors were informed of an incident of theft of garden furniture which had been reported to the Gardaí. Consideration was being given to improving the security at the front door and at other entrance points by the installation of closed circuit television cameras the inspectors were told. However, no additional safety features were in place at the time of the inspection. The inspectors also found that the area around the front entrance was hazardous for residents and visitors due to the constant flow of traffic and vehicles parking. This was particularly evident when there was an event in the church. The inspectors saw that the areas surrounding the centre became very busy and congested making access and use of the entrance area hazardous and unsafe for residents and staff.

There was a missing person policy in place which included clear procedures to guide staff should a resident be reported as missing. Photographic identification was available for each resident. There was a food safety system in place and the inspector viewed records indicating staff involved in food handling had been trained in food safety. The local environmental health officers inspect the main kitchen and the unit kitchens regularly. There were controls in place to ensure the temperature of hot water was restricted to 43°C at outlets and the inspectors found hot water was dispersed at a safe temperature. This had been highlighted as a risk factor in the action plan of the last report.

The inspector viewed records in staff files which indicated all staff had been trained in the safe moving and handling of residents. There were arrangements in place for recording and investigating untoward incidents and accidents. An accident record describing falls and near misses sustained by residents was maintained. There was a system to ensure learning for staff from accidents and from serious or untoward incidents as this was a regular topic at staff and management meetings.

The inspectors found that some improvements to risk management and health and safety management were needed. While an emergency plan was in place this was confined to advising staff of the actions to take in a medical emergency and did not provide information to guide staff when responding to other eventualities for example the loss of essential services such as a power failure. There were no contingency arrangements in place should it be necessary to evacuate residents from the building and the plan did not have guidance on how to manage critical

factors such as the transfer or movement of medication or essential equipment should an evacuation be required.

There was a visitors' log in place to monitor the movement of persons in and out of the building and this worked well during the day when the receptionist was on duty. However, this system did not work effectively at other times as everyone entering the building did not sign the visitor's book with the time they entered and left making it difficult to determine who was on site at times.

The required fire certificate from a suitably qualified person confirming the building meets all the statutory requirements of the fire authority in relation to the use of the building as a residential centre for older people was not available. The inspector was told that the centre was scheduled to have a fire inspection prior to this document being issued. Smoke detectors were located in bedrooms and general purpose areas. Emergency lighting was provided throughout the building. An inspector viewed contracts of the servicing of fire alarms, smoke and heat detectors. These were serviced on a contract basis. The inspector viewed records of fire drills which took place on a routine basis and found that all staff attended fire training regularly. Routine inspection of the fire door closures and fire alarm panel were undertaken by a member of maintenance staff to ensure they were operational. The inspector was told that the fire alarm system was due to be upgraded.

The inspectors found that some improvements to the fire safety arrangements were needed. Some pathways leading from exits were uneven which could make them hazardous during an emergency evacuation. There was a lack of signs to direct staff and residents when leaving the building and there was no designated assembly point in the grounds. The inspector was told that the fire safety system meant that evacuation out of the building was unlikely but this approach did not take into account the possibility that the centre may need to be evacuated for reasons other than a fire situation.

The environment was noted to be clean and there were measures in place to control and prevent infection. This included appropriate disposal arrangements for waste including clinical waste. All staff had training in infection control and had supplies of personal protective equipment which they were observed to use frequently. They were also observed to use the hand gels available throughout the centre as they moved from one area to another. However, the inspectors noted that some equipment such as shower trolleys and commodes needed more effective cleaning to adequately protect residents and staff from infection. A clinical waste bin outside St. Catherine's unit was not appropriately secured.

Outcome 6
Each resident is protected by the designated centres' policies and procedures for medication management.

References:
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Inspection findings

The inspector observed nurses during medication rounds and found that medication was administered safely. The systems in place for medication management had improved since the last inspection when an action plan to review the arrangements in place had been outlined with particular reference to the supply of medication, the prescribing arrangements and the documentation of errors. A blister pack system was now in place and had been in use for seven weeks. Staff reported satisfaction with the new process. Medication was now supplied by a local pharmacy. There was a policy and procedure that described the management and administration of medication. This was readily accessible to staff with a copy available on the medication trolleys.

The inspector noted that there was encouragement and support provided to residents who wished to manage their own medication. Prescriptions for medication were reviewed monthly by the pharmacist and a collective review was conducted three monthly by the medical officer, clinical nurse managers and pharmacist.

A significant effort had been made by nursing staff and the medical officer to review and reduce the use of psychotropic and sedative type medication where possible. This had led to a substantial reduction in the use of such medication. The inspector was told that some residents had improved quality of life outcomes as a result such as being more alert, having better swallowing reflexes and being able to sleep normally without sedation.

The inspector found evidence that while many medication management procedures were of an adequate standard that some improvements were required. Some medication administration charts lacked essential information. In instances where PRN medication was prescribed the maximum dose to be administered in a 24 hour period was not outlined in all cases. There were also some medications that had been discontinued but the date when the medication was stopped had not been indicated or appropriately signed. There were instances where medication was being crushed or administered covertly and this was not identified on the medication administration charts. There were block signatures for some medications –not all medications were individually prescribed in accordance with good practice. The inspector was told that where residents had swallowing problems a liquid form of the medication was procured if available.

The inspectors also noted that where residents were on critical medications that needed regular review such as Warfarin there were no care plans to guide staff on the procedures to follow to ensure that blood results were reported and medication dosages were titrated appropriately. The inspectors found some situations where verbal orders to change the dose of this medication were accepted.

Medications received in the centre were checked by a nurse but there was no process to determine if the pharmacy transcript/the prescription and the blister pack contents all collated accurately.

There was a process for audit of the medication administration system and an audit had been carried out on 15 June 2011. Errors were highlighted for remedial action and as part of a "learning from mistakes' culture. A medication error was noted to have occurred in May when a preparation had been prescribed for three days but was noted to have been administered for four additional days. The incident had been recorded by unit staff but it was unclear from the record what action had been taken to prevent another similar error.

Controlled drugs were secured in a locked cabinet. An inspector viewed the controlled drugs register. Controlled drugs were checked by two nurses at the change of each shift to ensure all drugs were accounted for. The quantity of four preparations checked was in accordance with the controlled drug register.

3. Health and social care needs

Outcome 7
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

References:
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Inspection findings

The inspectors found that staff had made significant improvements to the way care plans that documented residents' care needs and progress were maintained since the last inspection. They were working towards the appropriate standards for the completion of care documentation and had introduced a new care planning system. Recognised assessment tools were used to determine care needs, evaluate progress and to assess levels of risk in areas such as vulnerability to falls, nutrition, the potential to develop pressure sores and mobility problems. There were key nurses and healthcare staff allocated to a small number of residents.

This approach enabled staff to develop an in depth knowledge of the care needs of a small group and allowed for opportunities to develop more personal meaningful relationships that enhanced care practice inspectors were told.

The care planning system was new and the documentation was not fully complete for all residents. The inspectors findings are based on the varied sample examined. Care plans were reviewed at the required three month intervals and there was information available in some care plans that conveyed that the requirement to consult with residents in accordance with regulation 8- Assessment and Care Plan as part of the review had commenced. Information from assessment tools was noted to be used to inform care plans and to direct the actions of staff in some of the sample examined. However, the daily progress notes completed by staff were narrative in style and did not reflect the actions outlined in care plans or the targets for care practice.

There were good working relationships established with specialist services such as physiotherapists, occupational therapists and speech and language therapists. The geriatrician from the nearby hospital also did regular reviews of residents and was accessible for advice when needed according to staff. The inspectors found that improvements were needed in how instructions from other professionals were recorded and carried out. In one instance the specific instructions outlined by the speech and language therapist in April had not been followed through and these instructions were then outlined again for nursing and healthcare staff when deterioration in the health care status of the resident was noted and another review was requested. A further example where specific instructions were not followed was illustrated by the treatment provided to a resident following a fall. There were medical instructions that neurological observations were to be completed but the records examined did not have these observations recorded and there were no references in the daily nursing notes that these observations had been ordered and should be recorded.

Dependency levels were determined using a recognised assessment tool and almost 75% of residents were in the maximum to high dependency categories. The majority of residents were in advanced old age with over 50% of residents over 80 and in one unit, Our Lady's 75% of residents were over 90. The inspectors noted that staff were caring for a resident group where almost all residents had a number of complex medical conditions and a significant number had dementia or another mental health problem. The inspectors noted that there were improved standards of practice for residents with dementia care needs. An example of this was the emphasis on describing communication problems which was noted to have improved in all units. Staff in Our Lady's unit could describe specific behaviours that impacted on residents well being such as wandering and could outline the considerations that were needed to promote and preserve wellbeing such as additional calorie intake if there were persistent wandering behaviour. There were some improvements needed to the way dementia care problems were assessed and addressed. For example, there was a deficit in the information available that informed staff of residents' current abilities, their cognitive state, information such as who they still recognise or what reassurance or support was helpful if residents became distressed.

There was a commitment from staff to keep residents independent as long as possible and this was demonstrated by staff having good knowledge about what residents could do for themselves and what assistance they really needed although this was not documented. The inspectors also found that there was no system in place for the regular review of residents with dementia from specialist mental health services. If staff or the medical officer determined that a review was needed the resident had to be referred through the general referral process which could involve a time delay.

There were policies and procedures in place that guided the use of restraint. The inspector viewed the records for restraint and found that concerns for safety and falls risks were the main reasons for restraint measures. There was a risk assessment completed prior tor the use of the restraint. Clinical nurse managers told inspectors that there was now more discussion on restraint use as a result of training and the implementation of the new national guidance which emphasises working towards restraint free environments. There was now more thought and more comprehensive assessments applied to restraint use and measures were only put in place now as an option of last resort and when other alternatives had been explored and had not been beneficial. The inspectors were told that where family members had requested restraints to improve safety this was now being reviewed and a more consensus professional judgement was needed to support the use of restraint.

The inspectors examined practice in relation to wound care problems. They discussed practice with staff and examined the care records of residents who had wound care problems. Their findings indicated that practice needed improvement in a number of areas. These included:

- Descriptions of pressure areas in care records did not correspond in some cases with the treatment being provided. For example in a daily record a pressure area was described as “red” but was being treated as a stage 2 pressure wound.
- A resident with a wound that had been severe and which had shown some improvement had deteriorated but an expert assessment or new management plan had not been put in place. This resident’s care was subsequently reviewed and a new wound care management plan put in place.

Residents who had specific problems such as challenging behaviour or weight loss were identified but there were improvements needed to ensure their safety and well being based on the documentation the inspectors examined. Challenging behaviour was described well in one record examined and the actions taken by staff to manage the situation were clear and accountable.

Residents had access to a variety of scheduled activities. The programme was facilitated by a designated member of staff with support from nurses and health care assistants. Residents said that the variety of activities had been expanded during recent months. Activities that take place regularly include card playing, newspaper reading, music sessions and one to one work with residents who need to spend time in bed or who prefer to be on their own. The inspectors noted the efforts that had been made to ensure that the range of activities were appealing to residents and

appropriate to their needs. They were reassured by staff that this was an area that they continued to address and make more appropriate. Health care assistants said that they completed the "Key to Me" document for their own designated residents and together with the Pool Activity Checklist Assessment (PAL) this formed the basis of social care plans being developed with residents. The inspectors saw that staff took time to include residents with cognitive impairment and other communication difficulties in conversations and encouraged them to talk and contribute according to their abilities. There was access to computer facilities and broadband for residents and these were observed to be in regular use. Questionnaires returned to the inspectors confirmed that there were regular activities provided.

Access to specialist health professionals such as physiotherapists, occupational therapists, speech and language therapists and medical staff was appropriate and timely. There had been problems with adequate access to a dietician but this was being resolved by the person in charge and provider who were reviewing current arrangements. The inspectors met with the medical officer who was familiar with the regulatory process. She described her input to the centre and the efforts being made to improve standards of care. She said that together with the staff team she regularly reviewed medication and had also contributed to the discussions on end of life care and resuscitation.

Questionnaires completed by relatives confirmed they were satisfied with information provided by staff about their family members' healthcare and general wellbeing.

Outcome 8
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

References:
Regulation 14: End of Life Care
Standard 16: End of Life Care

Inspection findings

Nursing staff described the person-centred care approach that applied to care at end of life and said that their actions were based on residents wishes and consultation with family or significant others. Family members were encouraged to remain in the centre when residents were critically ill and the emphasis was on providing appropriate care and comfort to each resident approaching end of life. There was a single room available in three units that allow families privacy to support their relative and there were over night facilities for relatives if required. This was confirmed by a relative who described his experience to the inspector and outlined how well end of life care was managed for his relative. He described the comfort offered and compassion shown by staff and said that he was welcomed at all times and could stay as long as he wished. Relatives also said they found comfort from the annual memorial service that takes place in the centre.

There were good multidisciplinary working relationships established with the palliative care team and staff told inspectors and there was an end of life policy in place that guided practice. Training had been provided for staff on end of life care, communicating with the dying and respecting their wishes and incorporating families into the end of life care planning.

The inspectors reviewed care plans and noted the decisions made in relation to end of life care in resident's care plans. There was an indicator for staff that identified if resuscitation procedures were to be used in the event of a medical crisis. This decision was documented by the medical officer following discussion with residents, significant others and staff. However, in some cases it was unclear who had made the decisions on the residents' behalf. It was also not clear in some cases where others had made decisions on the resident's behalf that the resident did not have capacity to make the decision themselves. The inspectors found that further development of the procedures that apply was required in this area.

There is no single room on St. Michael's unit which compromised the way end of life care can be managed there. The centre has a mortuary but it was noted to be in poor condition and no longer fit for purpose. The inspectors were told that it had not been used for some time and that it would not be used in its present condition.

Outcome 9
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

References:
Regulation 20: Food and Nutrition
Standard 19: Meals and Mealtimes

Inspection findings

Residents told inspectors that the food served was very good and that they had varied meals that offered choice and variety. The mealtime arrangements had improved in all units with the provision of better dining space and more emphasis on making meal times unhurried occasions that provided an opportunity for residents to interact with each other and with staff. Inspectors spoke to staff assisting and serving the meals in the dining areas and found they were knowledgeable about individual resident's specialised needs such as a pureed or minced diets and individual dietary restrictions. Residents who required assistance at meal times were assisted appropriately and sensitively. There was a four week menu cycle that offered choices at all mealtimes. Residents were observed to make special requests for food and fluids at varied times and staff provided the items requested without difficulty the inspectors noted.

A recognised nutrition assessment tool Malnutrition Universal Screening Tool (MUST) was in use and there was regular monitoring of residents' weights to assess fluctuations. Residents who were being monitored for weight changes had treatment

plans in place but there was poor compliance with the some of the actions identified as necessary. For example the inspectors found that fluid balance and nutrition charts were not fully complete and were not totalled at the end of the 12/24 hour period of use and could therefore not provide an indicator that fluid/nutrition intake was adequate. Access to the services of a dietician had been problematic but arrangements were in place to address this deficit the inspectors were told by the provider and person in charge.

The main kitchen was suitable in size to cater for residents' needs and the number of meals prepared each day. It was clean, well equipped and contained suitable facilitates for the storage, preparation and cooking of food. It was well stocked with a plentiful supply of vegetables, fruit and meat. There was a good supply of fruit juices, beverages and snack foods. Staff at night had access to food supplies for residents if needed.

The inspectors found that the heated trolley from which meals were served in Our lady's unit was located on the main corridor during meal times. This caused an obstruction and was hazardous to anyone walking through the unit. The inspectors formed the view that this arrangement could be reviewed as there was now sufficient space to serve meals in the new dining areas.

4. Respecting and involving residents

Outcome 10
Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

References:
Regulation 28: Contract for the Provision of Services
Standard 1: Information
Standard 7: Contract/Statement of Terms and Conditions

Inspection findings

Residents had been provided with a contract of care. However, there were two formats of the contract in use. The person in charge explained that the contract of care had changed and that a new format had been finalised and was being issued to all residents. The inspectors were pleased to note the efforts being made to ensure that residents and families understood the contract, how charges applied and the arrangements that applied to Fair Deal.

Outcome 11
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.

References:
Regulation 10: Residents' Rights, Dignity and Consultation
Regulation 11: Communication
Regulation 12: Visits
Standard 2: Consultation and Participation
Standard 4: Privacy and Dignity
Standard 5: Civil, Political, Religious Rights
Standard 17: Autonomy and Independence
Standard 18: Routines and Expectations
Standard 20: Social Contacts

Inspection findings

The inspectors found that there were arrangements in place to enable residents to convey their views about the service and to influence change. Residents' meetings took place regularly. Inspectors read the minutes from some of the meetings and noted a good attendance by residents. Suggestions by residents had been implemented for example, to get out more and to have a better range of activities. Another example where residents influenced a significant decision was the change to the dining and sitting areas in the newly refurbished St. Catherine's unit. Residents suggested that if the areas were swapped around they would work more effectively and this was done to good effect. Residents said that they had recently enjoyed going to football matches and going in to town to do some shopping. Many residents were included in the general business of the centre and helped with activities such as delivering post, organising the church or assisting at meal times.

There were limitations for some residents on their participation in the organisation of the centre, given their high dependency levels and problems such as memory difficulties or cognitive impairment. To overcome this challenge, staff said they made special efforts to assist residents' express their preferences. There was evidence of open communication between the person in charge, staff and relatives, as inspectors observed relatives talking freely with staff. Inspectors observed good interactions between staff and residents and it was obvious that they knew each other well and staff were observed spending time talking to residents and relatives confirmed that this was usual practice.

Inspectors observed that residents had access to televisions, newspapers and telephones. There were notices boards located around the building containing information on the activities planned for the day, the menu options and the complaints procedure.

Residents could practice their religious beliefs and worship according to their wishes. There is a church on site and a prayer room in St. Catherine's unit. Mass was scheduled six days a week and arrangements were in place for residents of other faiths to have access to clergy and ministers.

Outcome 12
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

References:
Regulation 7: Residents' Personal Property and Possessions
Regulation 13: Clothing
Standard 4: Privacy and Dignity
Standard 17: Autonomy and Independence

Inspection findings

The laundry was clean and well organised. All clothes were marked to indicate ownership. No concerns were raised regarding items of clothing going missing. Residents told inspectors in conversations that they could choose what they wore each day and said that their belongings were well cared for.

There was a policy on the management of residents' personal property and possessions. A property list was maintained for each resident and these were viewed by inspectors. As previously described the property records detailed the items brought to the centre on admission but the records were not updated when new items were acquired by residents. Nursing staff were aware of this deficit and said that when the format for care plans had been reviewed this record had not been included.

Residents' were encouraged to personalize the space around their beds. Many residents had photographs, ornaments and pictures located on bedside lockers or around the vicinity of their beds. Each resident was provided with a lockable facility by their bedside to allow them secure personal possessions. However, there was very limited space for residents to store clothing in the wardrobe space provided in multiple occupancy bedrooms and this restricted residents' choices.

5. Suitable staffing

Outcome 13
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

References:
Regulation 15: Person in Charge
Standard 27: Operational Management

Inspection findings

The post of the person in charge was full time and she had the required experience working with older people for three years within the last six that was defined by

legislation. She demonstrated that good governance procedures were now in place to ensure effective operational management of the centre, the provision of clinical care and the general welfare and protection of residents. The person in charge was supported in her role by an assistant director of nursing who also worked full time and who took charge in her absence. Each unit had clinical nurse managers who were responsible for the day to day running of their units and who reported to the assistant director of nursing and the person in charge.

The inspectors interviewed the person in charge and were satisfied she had the qualifications, skills and experience to ensure the centre meets its stated purpose, aims and objectives. She had relevant experience and clinical knowledge to provide leadership and guidance for the team.There was evidence that she had a commitment to her own continued professional development. Throughout the three day inspection she demonstrated good knowledge of the regulations and standards. The person in charge demonstrated a sufficient knowledge of clinical audit and had processes in place for auditing information to identify trends and improve the quality of service available to residents.

The inspectors talked to several members of the staff team during the inspection. They were clear about their areas of responsibility and the line management structure. They knew the nominated provider Catherine Cunningham and felt that there was a good team structure that supported staff at every level. Staff also confirmed that there was a good team spirit and sense of cooperation developed throughout the centre with a shared understanding that that providing a good quality service to residents was everyone's duty.

Outcome 14

There are appropriate staff numbers and skill-mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

References:

Regulation 16: Staffing
Regulation 17: Training and Staff Development
Regulation 18: Recruitment
Regulation 34: Volunteers
Standard 22: Recruitment
Standard 23: Staffing Levels and Qualifications
Standard 24: Training and Supervision

Inspection findings

The centre employs a total of 104 staff. The inspectors viewed the staff duty rota for a two week period. The rota showed the staff complement on duty over each 24-hour period. The staff roster detailed the position and name of the staff on duty including the person in charge and assistant director of nursing. From discussion with

staff, residents and relatives, inspection of the duty rota and observation of care practices, inspectors were satisfied that there was an appropriate skill mix of staff and adequate numbers to meet the needs of residents during the day, however staff numbers reduced significantly in the late afternoon and during the evening and night time periods. The staff numbers on most units reduced by 50% with only one nurse on duty in each unit after 5 pm to oversee clinical care. The inspectors formed the view that the deployment of staff needed review and that staff numbers needed to be deployed more equitably over the 24 hour period to ensure appropriate care for residents. The high level of dependency of the resident group, the significant needs of residents who are admitted for rehabilitation purposes and the stated emphasis on maintaining residents' independence were indicators that the considerable depletion in staff numbers for the majority of the 24 hour period did not facilitate the achievement of the centre's aims and objectives and did not enable staff to provide high quality care throughout the 24 hour period. There were other indicators that support the view that staff deployment needed review. These include the findings that care records needed improvement, reports from residents and relatives that staff were very busy during the evening and the time commitment to admissions for respite care that usually took place in the afternoon and evenings.

This finding was also described in the last inspection report and the action plan to have available appropriate numbers of staff and appropriate skill mix available over the 24 hour period is repeated in this report. In the questionnaires returned to the inspectors all relatives said they found there was adequate staff on duty during the day but that during the evening staff numbers were reduced and comments were made that indicated some concern about staffing levels during the evening.

Staff told inspectors that copies of both the regulations and the standards had been made available to them and that they discussed these at staff meetings as well as the outcomes of previous reports and the new regulatory system in general.

The HSE policy and personnel systems for the recruitment, selection and vetting of staff was in place. There had been no recruitment since the moratorium on staff recruitment had been applied. A sample of staff files were examined to determine that the documentation described in Schedule 2 was available in respect of persons employed to work with vulnerable people. All the information required by Schedule 2 of the regulations was available in the staff files reviewed. The person in charge maintained a record of An Bord Altranais PINs (professional identification numbers) for all registered nurses. This was reviewed by inspectors and seen to be up to date. Two regular volunteers in the centre receive an acceptable level of supervision and support and were vetted appropriate to their role and level of involvement.

The provider and person in charge were committed to providing on going training for staff. Mandatory training in adult protection, moving and handling and fire safety had been completed by all staff. Six nursing staff have the higher diploma in gerontology and a third of care staff have Further Education and Training Awards (FETAC) at level five. A range of other training courses was undertaken by staff. This included dementia care, infection control and food safety. Staff had also had training in end of life care.

The inspectors were told that further training was planned to develop staff skills in the area of dementia care and this included training on dementia care mapping.

6. Safe and suitable premises

Outcome 15
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Inspection findings

The building is one storey and is approached by a tarmac driveway. There is parking to the front and to the side of the building. The centre was welcoming and the internal areas viewed were in a clean hygienic condition. There were pictures and photographs of residents and staff taking part in events displayed throughout the centre which contributed a home like touch. All units had appropriate provision of communal space and there were areas where residents could see visitors in private located throughout the centre. Significant improvements had been made since the last inspection with a major decorating programme completed and a refurbishment of Our Lady's unit that provided appropriate sitting and dining space away from residents' bedroom areas.

There were systems in place for the repair and maintenance of equipment and the building. There was assistive equipment such as call bells in place. Residents were familiar with the system and found it easy to use the inspectors were told.

Hallways had handrails to assist people with mobility problems. Safe floor covering was provided throughout the building. The inspector observed residents move freely around the building. Staff had made a significant effort to promote the values of privacy and dignity by making adaptations to areas of multiple occupancy and by reducing the number of residents accommodated in bedroom areas from 6 to 4. Although the age and layout of the building presented significant challenges, the recent refurbishments had resulted in a warm welcoming environment being created for residents. There was evidence of an ongoing programme of decoration and maintenance and several areas such as halls and sitting areas had been recently re-decorated.

Staff facilities were provided and included a dining area, toilets and showers. Separate facilities were provided for catering and care staff in accordance with good practice for infection prevention.

Inspectors found there was appropriate assistive equipment available such as specialised beds, hoists, pressure relieving mattresses, wheelchairs and walking frames. There was a maintenance arrangement that covered the breakdown and repair of beds, air mattresses and other equipment used by residents. Inspectors reviewed maintenance records and found that the equipment was maintained and serviced regularly. Staff had started to compile an inventory of all equipment to identify exactly what was available and fit for use and what items needed repair or replacement.

The physical environment did not comply fully with the specifications of the *National Quality standards for Residential Care Settings for Older People in Ireland.* While improvements had been made to the personal space available for residents the following factors impacted on privacy.

The majority of residents were accommodated in multi occupancy rooms with beds opposite each other. There was little capacity to create a home like environment. The space restrictions although not as restrictive as noted on previous inspections did not allow residents to have their own identified space and hindered the levels of privacy available to them. Space that allowed for a chair by the bed or to accommodate visitors was also limited.

There were a sufficient number of toilets for the number of residents now accommodated. However, some toilets were not accessible to residents using wheelchairs and were not of sufficient size to accommodate those requiring the use of a hoist. The toilet areas in St. Joseph's and St. Michaels needed decoration and upgrading.

7. Records and documentation to kept at a designated centre

Outcome 16
The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

References:
Regulation 21: Provision of Information to Residents
Regulation 22: Maintenance of Records
Regulation 23: Directory of Residents
Regulation 24: Staffing Records
Regulation 25: Medical Records
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

Inspection findings

** Where "Improvements required" is indicated, full details of actions required are in the Action Plan at the end of the report.*

Resident's guide

Substantial compliance ☒ Improvements required* ☐

Records in relation to residents (Schedule 3)

Substantial compliance ☐ Improvements required* ☒

The records required by schedule 3 were all in place but as outlined throughout this report particularly in outcomes six, seven and eight there were records that needed improvement to ensure that residents' care needs were described accurately and completely.

General records (Schedule 4)

Substantial compliance ☐ Improvements required* ☒

The inspectors have described that improvements were needed to the records maintained of valuables retained for safe keeping and to the complaints records.

Operating policies and procedures (Schedule 5)

Substantial compliance ☐ Improvements required* ☐

The provider had all the policies required by Schedule 5 of the Regulations. Inspectors viewed a sample of polices and found that the majority were well written and guided practice. However, as stated in outcomes three, four, and eleven, some policies did not sufficiently inform practice and required review. For example the elder abuse policy did not outline the requirement to inform the Authority of any allegation, suspected or confirmed abuse of any resident in accordance with regulation 36.

Directory of residents

Substantial compliance ☒ Improvements required* ☐

Staffing records

Substantial compliance ☒ Improvements required* ☐

Medical records

Substantial compliance ☐ Improvements required* ☒

The records outlining residents nursing and medical care required improvements in several areas to appropriately outline care needs and treatments provided. This included for example daily records maintained by nurses and the completion of nutrition and fluid balance charts.

Insurance cover

Substantial compliance ☒ Improvements required* ☐

Outcome 17
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

References:
Regulation 36: Notification of Incidents
Standard 29: Management Systems
Standard 30: Quality Assurance and Continuous Improvement
Standard 32: Register and Residents' Records

Inspection findings

The person in charge and staff were aware of the majority of notifications to be made to the Authority and the time scale for the submission of such notifications in accordance with regulation 36-Notification of Incidents. However, practice in relation to notifications of incidents needed some improvement. The presence of infections and a significant pressure wound assessed at grade four had not been reported. The reported theft of the garden furniture was due to be included in the next quarterly notification.

Outcome 18
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

References:
Regulation 37: Notification of periods when the Person in Charge is absent from a Designated Centre
Regulation 38: Notification of the procedures and arrangements for periods when the person in charge is absent from a Designated Centre
Standard 27: Operational Management

Inspection findings

There were appropriate arrangements in place for the absence of the person in charge. The assistant director of nursing would take on the responsibility for managing the service. The provider was aware of her responsibility to notify the Authority of the extended absence of the person in charge and the arrangements in place to cover this absence.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider, the person in charge, clinical nurse managers and others to report on the inspectors' findings, which highlighted both good practice and where 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:

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Social Services Inspectorate
Health Information and Quality Authority

25 November 2011

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report*

Centre:	Sacred Heart Hospital
Centre ID:	0654
Date of inspection:	11, 12 and 13 October 2011
Date of response:	23 December 2011

Requirements

These requirements set out the actions that must be taken to meet 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*.

Outcome 1: Statement of purpose and quality management

1. **The person in charge is failing to comply with a regulatory requirement in the following respect:**

The staffing levels and skill mix did not adequately meet the assessed needs of residents over the 24 hour day taking into account the centre's aims and objectives and the size and layout of the centre.

Action required:

Review the statement of purpose in the context of the staff available to meet the aims and objectives as described in the statement of purpose.

Action required:

Submit a copy of the revised statement of purpose to the chief inspector.

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

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: Currently reviewing statement of purpose in the context of the staff available to meet the aims and objectives. A copy of revised statement of purpose will be submitted to Chief Inspector.	28 February 2012

Outcome 2: Reviewing and improving the quality and safety of care

2. The provider is failing to comply with a regulatory requirement in the following respect: A report on the quality and safety of care and quality of life of residents in accordance with regulation 35 was not available.	
Action required: Establish and maintain a system for reviewing the quality and safety of care and quality of life of residents in the designated centre.	
Action required: Prepare a report in respect of any review conducted and make this available to residents and the Chief Inspector (on request).	
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: The monthly monitoring of quality and safety of care of residents and recent Quality of Life review will be reviewed at local Governance meeting and resident meetings. Going forward an annual report will be complied on reviews conducted and will be available to residents and the Chief Inspector.	Immediate

Outcome 3: Complaints procedures

3. The provider is failing to comply with a regulatory requirement in the following respect: The process of managing complaints needed review to comply with regulation 39 Complaints Procedures. The investigations and actions undertaken to resolve some complaints were not evident in the records of complaints that were reviewed. The outcomes were not clearly described and it could not be determined if the complainant was satisfied with the outcome. The inspectors found that it was difficult to determine that a complete record of complaints was available and the appeals process needed clarification.
Action required: The provider shall maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.
Action required: Outline the independent appeals process and review the information provided in respect of the Authority.
Reference: Health Act 2007 Regulation 39: Complaints Procedures Standard 6: Complaints

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A review of the complaints procedure is planned by Roscommon Complaints Officer to ensure the above actions are addressed.	15 January 2012

Outcome 4: Safeguarding and safety

4. The provider is failing to comply with a regulatory requirement in the following respect: Staff had not identified that an event-theft that had been reported could be abuse and the abuse procedure did not outline the requirement to report to the Authority any allegation, suspected or confirmed abuse of any resident.
Action required: Provide additional training for staff in elder abuse and the protection of vulnerable people.

Action required:

Put in place a policy on and procedures for the prevention, detection and response to abuse including the legal requirement to notify the Authority.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection and
Regulation 36: Notification of Incidents
Standard 8: Protection

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
The "event-theft" mentioned above was not a theft or abuse - this money was found subsequent to inspection on 20 October 2011 in the resident's cardigan. Email was sent to the Health Information and Quality Authority on 25 October 2011.	25 January 2011
All staff have been trained in Elder Abuse and an audit was carried out on effectiveness of training which was positive. Further training is planned for January 2012.	31 January 2012
We have a policy in place for prevention, detection and response to abuse which includes the legal requirements to notify the authority (recently updated).	20 December 2011

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

An up to date record of residents' property was not maintained as new items acquired by residents were not recorded. A record of items deposited for safe keeping was not systematic and did not always indicate when the items had been deposited, who had left the items for safe keeping or when items were returned to residents and what items remained.

Action required:

The provider shall ensure that all records kept in accordance with schedule 4 including records of money and other valuables are up to date.

Action required:

The provider shall maintain the record in a manner that states the date on which the money or valuables were deposited or received, the date returned to the resident and shall include a written acknowledgement of the return of the money or valuables.

Reference: Health Act, 2007 Regulation 22: Maintenance of Records Standard 9: The Resident's Finances

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We shall ensure that all records kept in relation to money or valuable that we have in safe keeping are up to date. In so far as possible records of residents property will be updated as new items are acquired by residents.	20 December 2011

Outcome 5: Health and safety and risk management

6. The provider is failing to comply with a regulatory requirement in the following respect: While there was a system for the identification of risk there were a number of risk areas that had not been identified for attention. These included security around and inside the building, monitoring of access to the premises and traffic management at the entrance. The inspectors found that the heated trolley from which meals were served in Our lady's unit was located on the main corridor during meal times. This caused an obstruction and was hazardous to anyone walking through the unit.
Action required: Have in place a system that records the time that all visitors enter and leave the premises.
Action required: Have in place security arrangements that protects residents and staff and ensure that there are appropriate safety measures in place to prevent accidents.
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Regulation 30:Health and Safety Standard 26: Health and Safety

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A visitor book is in place with signage requesting visitors to comply with above.	20 December 2011

Risk assessments are being carried out on security of both inside and around the building and on heated trolleys in ward corridor.	31 January 2012

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

The emergency plan was confined to providing guidance for staff in medical emergencies and did not take in to account the range of other emergency situations that staff may encounter.

Action required:

Outline an emergency plan that provides guidance for staff in a range of emergency situations including guidance on the actions to take should the premises needed to be evacuated.

Action required:

Provide training /information for staff on the actions to take in an emergency.

Reference:

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

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Review emergency plan to include guidance in a range of emergency situations.	28 February 2012

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

Improvements were needed to fire and emergency procedures. Some pathways leading from exits were uneven and consequently hazardous to use during an emergency evacuation. There was a lack of signs to direct staff and residents when leaving the building and there was no designated assembly point in the grounds.

Action required:

Make adequate arrangements for the evacuation, in the event of fire, of all people in the designated centre and the safe placement of residents.

Action required:

Provide adequate means of escape in the event of fire including providing sufficient signage throughout the building to guide staff and residents to fire exits and identify an assembly area in the grounds for emergency situations.

Action required:

Submit written confirmation (on the Authority's document) from a competent person that all requirements of the statutory fire authority have been complied with.

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:	
A fire safety compliance has been carried out in the Sacred Heart Hospital for the HSE and we await the report.	31 January 2011
The maintenance manager has reviewed the external pathways and work is planned for early 2012, weather permitting.	30 April 2011

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

Some equipment such as shower trolleys and commodes needed more effective cleaning to adequately protect residents and staff from infection. A clinical waste bin outside St. Catherine's unit was not appropriately secured.

Action required:

Have a system in place to ensure that there is comprehensive identification and assessment of risk throughout the premises including infection control risks.

Action required:

Ensure that all equipment is maintained in a clean hygienic condition and that hazardous waste is secured appropriately.

Reference:

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

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Risk Management system in place. Clinical Waste Bins are now secured appropriately. Schedule of cleaning of equipment is in place. Monthly audit of equipment will now take place. Hygiene audits are carried out and findings of same are documented and addressed.	12 December 2011

Outcome 6: Medication management

10. The provider is failing to comply with a regulatory requirement in the following respect: There were aspects of medication management that were not in accordance with legislative and professional standards. As required (PRN) medication prescribed did not have the maximum dose to be administered in a 24 hour period outlined in all cases. Medications that had been discontinued did not have the date when the medication was stopped and were not appropriately signed. Medication was being crushed or administered covertly and this was not identified on the medication administration charts. There were block signatures for some medications which is not in accordance with best practice for medication management and there was no procedure in place for the management of medications that required special precautions.
Action required: Ensure that there are appropriate and suitable practices relating to the prescribing and administration of PRN (as required) medication.
Action required: Ensure that all medication is individually prescribed.
Action required: Ensure that the route for the administration of medication is outlined for all medications.
Action required: Have in place a protocol to guide staff when administering medications that require special precautions.

Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medication. Standard 14: Medication Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We are liaising with Medical Doctor re prescribing PRN max dosage. We will put in place a protocol to guide staff when administering medications that require special precautions. Liaising with Medical Doctor re individual signing of medication. We will ensure that route for administration of medication is outlined for all medications.	 15 January 2011 15 January 2012 15 January 2012 15 January 2012

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

The arrangements for medication management did not provide an adequately rigorous system for checking that the supply of medication was in accordance with the original prescription and where medication errors occurred it was not evident what changes were made to prevent a recurrence.

Action required:

Have in place a system that verifies that the medication received in the centre is in accordance with the medication as prescribed.

Action required:

Have in place a system that provides a record of errors and the actions taken to prevent a recurrence.

Reference: Health Act 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medication Standard 14: Medication Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: We are currently exploring systems on checking that medication received in the centre is in accordance with the medication as prescribed. Medication errors are documented and reviewed and learning from same is shared and implemented.	 31 January 2012 20 December 2012

Outcome 7: Health and social care needs

12. The person in charge is failing to comply with a regulatory requirement in the following respect: The daily records were narrative in style and did not reflect the assessment tools or the targets for care practice outlined in care plans. There were improvements needed to the way dementia care problems were assessed and addressed. For example, there was a deficit in the information available that informed staff of residents' current abilities and their cognitive state that would guide and inform staff actions.
Action required: Provide an adequate record of the person's health and condition and treatment given on a daily basis in accordance with relevant professional guidelines.
Action required: Ensure that the daily record reflects the assessed needs outlined in care plans and includes residents' activities and wellbeing throughout the day.
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Regulation 25: Medical Records 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: Further work is going to take place on care plans to ensure the narrative notes in conjunction with the flow chart will reflect the residents activities & wellbeing throughout the day. Further training is planned to take place on care plans. Six staff including the person in charge have completed dementia care mapping training since the inspection.	 15 March 2012

13. The person in charge is failing to comply with a regulatory requirement in the following respect:

Instructions from healthcare professionals were not documented and followed to ensure residents received the best possible health care and treatment. The specific instructions outlined by the speech and language therapist had not been followed and neurological observations had not been carried out in accordance with medical instructions in two examples noted by inspectors.

Action required:

Facilitate all appropriate health care and support each resident on an individual basis to achieve and enjoy the best possible health.

Action required:

Have in place a system to ensure that medical and other treatments recommended are carried out appropriately to ensure appropriate health care is facilitated.

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: We will implement the above and will ensure that instructions outlined by therapy staff are carried out.	15 January 2012

14. The person in charge is failing to comply with a regulatory requirement in the following respect:

The description of wound care problems was inconsistent and not in line with good practice standards. A resident with a wound that had been severe and which had shown some improvement had deteriorated but an expert assessment or new management plan had not been put in place. Another wound was being treated as a grade 2 pressure wound but was described in different ways in care documentation.

Action required:

Have in place a procedure for the identification and management of wound care problems that is consistent across all units. Ensure that the procedure includes directions for staff to guide their practice when wound care problems are identified to prevent deterioration such as the commencement of position changes, a review of nutrition and access to expert tissue viability advice.

Action required: Provide training for staff in wound care identification and management.
Reference: Health Act 2007 Regulation 6: General Welfare and Protection Regulation 31: Risk Management Procedures Standard 13: Healthcare

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Wound policy is in place and audit of current wound practice is being planned. Ongoing training is being provided in wound care identification and management.	 31 January 2012 Ongoing

Outcome 8: End of life care

15. The provider is failing to comply with a regulatory requirement in the following respect: End of life care policies and procedures needed further development as it was unclear in some cases where decisions were made by others about resuscitation procedures where the resident did not have capacity to make a decision or contribute to the decision. In one unit there was no facility to provide privacy at end of life.
Action required: Put in place written operational policies and protocols for end of life care.
Action required: The person in charge shall ensure that where possible that each resident's choice as to the place of death including the option of a single room or returning home is identified and facilitated.
Reference: Health Act, 2007 Regulation 14: End of Life Care Standard 16: End of Life Care

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: We are currently reviewing our end of life care policies to include resident and or family involvement. PIC shall ensure that each person choice is facilitated at end of life. This will be included in the policy also.	30 January 2012

Outcome 9: Food and nutrition

16. The person in charge is failing to comply with a regulatory requirement in the following respect:

There was poor compliance with the some of the actions identified as necessary to ensure that vulnerable residents had adequate fluids and nutrition. Fluid balance and nutrition charts were not fully complete and were not totalled at the end of the 12/24 hour periods of use and did not provide adequate monitoring of fluid/nutrition intake. The instructions of the speech and language therapist had not been appropriately put in place.

Action required:

Implement a comprehensive policy and guidelines for the monitoring and documentation of nutritional intake.

Action required:

Provide appropriate assistance to residents who, due to infirmity or other causes require such assistance with eating and drinking including following the instructions provided by specialists.

Reference:

Health Act, 2007
Regulation 20: Food and Nutrition
Standard 19: Meals and Mealtimes

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We will maintain accurate fluid & food charts. Assessments and guidance from therapist will be adhered too.	20 December 2011

Outcome 12: Residents' clothing and personal property and possessions

17. The person in charge is failing to comply with a regulatory requirement in the following respect: Residents had limited space to store their own clothes due to the multiple occupancy arrangement of rooms and the personal space available for furniture.
Action required: Provide adequate arrangements for residents to appropriately store, maintain and use their own clothes.
Reference: Health Act, 2007 Regulation 13: Clothing Standard 4: Privacy and Dignity

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We are looking at the space we have, with a view to providing more space for residents to store their clothes. Additional wardrobes and drawers have been purchased for residents.	31 January 2012

Outcome 14: Suitable staffing

18. The person in charge is failing to comply with a regulatory requirement in the following respect: The process for determining staffing levels and skill mix over the 24 hour period was not based on the assessed needs of residents and size and layout of the building. Inspectors found that there were indicators that suggested there were inadequate staffing levels and skill mix during the evening and night time to ensure appropriate care for residents.
Action required: Establish a process to determine the numbers and skill mix of staff that are appropriate to the assessed needs of residents and the size and layout of the designated centre.
Action required: Provide staff in sufficient numbers and in a skill mix appropriate to meet the needs of residents throughout the day and night.

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 staffing level, skill mix, taking into account our residents needs and dependency within the current moratorium.	31 March 2012

Outcome 15: Safe and suitable premises

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

There were a number of areas where the premises did not meet the criteria of the *National Quality Standards for Residential Settings for Older People in Ireland.*

Accommodation was mainly provided in multi-occupancy rooms where four residents were accommodated.

Toilets in St. Michael's and St. Joseph's units needed redecoration.

There is no single room on St.Michael's unit which compromised the way end of life can be managed there as described in outcome 8.

Action required:

Plan for changes to the physical design and layout of the premises to meet the needs of each resident taking into account their dependency needs, the requirements for the use of equipment and the need to have treatment rooms when residents are cared for in multiple occupancy rooms.

Action required:
Make suitable provision for storage in the designated centre including space for residents to hang their clothes, secure their belongings and make appropriate arrangements for the storage of equipment that does not impact on residents' personal space.

Reference:
Health Act, 2007
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: The area available at the Sacred Heart is being explored so as to provide a treatment room, storage space for residents and equipment space.	31 March 2012

Outcome 16: Records and documentation to be kept at a designated centre

20. The provider is failing to comply with a regulatory requirement in the following respect: Some of the Schedule 3 and Schedule 4 records for example residents' care records and property records were not fully complete and up to date.
Action required: Maintain the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) so as to ensure completeness, accuracy and ease of retrieval.
Action required: Ensure all records are kept up to date and in good order.
Reference: Health Act, 2007 Regulation 22: Maintenance of 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: Resident care plans/records and property records will be updated. An audit of care plans is planned for January 2012.	31 January 2012

Outcome 17: Notification of incidents

21. The person in charge is failing to comply with a regulatory requirement in the following respect: Practice in relation to notifications of incidents needed improvement. The presence of infections and a significant pressure wound assessed at grade 4 had not been reported.

Action required: Give notice to the Chief Inspector without delay of the occurrence in the designated centre of outbreaks of any infectious disease.	
Action required: Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any serious injury to a resident including the presence of pressure sores at grade 2 or above.	
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: We will ensure that all notifiable incidents are notified to HIQA as per appropriate regulations.	Immediately

Any comments the provider may wish to make:

Provider's response:

None supplied

Provider's name:

Date: 18 January 2012