

**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



Centre name:	Sacred Heart Residence
Centre ID:	OSV-0000157
Centre address:	Little Sisters of the Poor, Sybil Hill Road, Raheny, Dublin 5.
Telephone number:	01 833 2308
Email address:	ast.raheny@lspireland.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Little Sisters of the Poor
Provider Nominee:	Theresa Martin
Lead inspector:	Jim Kee
Support inspector(s):	Philip Daughen; Sheila McKevitt
Type of inspection	Unannounced
Number of residents on the date of inspection:	83
Number of vacancies on the date of inspection:	3

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 05 April 2016 09:15 To: 05 April 2016 18:30

The table below sets out the outcomes that were inspected against on this inspection.

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Non Compliant - Major
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Major
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 15: Food and Nutrition	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Major

Summary of findings from this inspection

The purpose of this inspection was to follow up on non-compliances identified during the last inspection of the centre on 12/11/2015 and to monitor on-going compliance with the Health Act 2007 (Care and Welfare of Residents in Designated centres for Older People) Regulations 2013. The inspection also included a focused review of fire safety management arrangements in the centre as outlined in outcome 8. As part of the inspection, the inspectors met with residents and staff members. The inspectors observed practices and reviewed relevant documentation including care plans, medical records, and policies and procedures. The Health Information and Quality Authority (HIQA) had also received information relating to this centre, primarily regarding staffing levels, and supervision of staff. The outcome on staffing was found to be in major non-compliance with the regulations.

There were 83 residents residing in the centre at the time of inspection. The person in charge was present throughout the inspection. Overall inspectors found that the governance and management systems in place in the centre were not sufficient to ensure the service provided was safe, appropriate, consistent and effectively monitored. The outcome on governance and management was found to be in major

non-compliance with the regulations. Ten of the actions identified to address non-compliances found during the inspection in November 2015 had not been satisfactorily implemented.

One outcome on notifications was deemed to be in compliance with the regulations.

The outcomes on health and safety and risk management, health and social care needs, food and nutrition and documentation were found to be moderately non-compliant.

The outcomes on safeguarding and medication management were also found to be in major non-compliance with the regulations.

The action plan at the end of the report identifies those areas where improvements were required in order to comply with the regulations and the authority's (HIQA) standards. Eleven actions are the responsibility of the registered provider to address, and five actions are the responsibility of the person in charge.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

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

Findings:

The aspects of this outcome reviewed during the inspection included the actions to be completed by the provider to address the non-compliances identified during the previous inspection on 12/11/2015. The management structure in the centre had changed and HIQA had been notified regarding the nomination of the operations manager as the provider nominee. There had been no other changes to the management structure since the last inspection. The centre had unsuccessfully advertised for a clinical nurse manager as outlined in outcome 18. The management in the centre consisted of the operations manager, the person in charge and the assistant director of nursing. The management team had made some improvements in the system of auditing and had commenced work on completing the annual review. However the management systems in place in the centre required significant further improvement to ensure the service being provided was safe, appropriate, consistent and effectively monitored. The following non-compliances had not been sufficiently addressed:

- management system in place including system of auditing, and system of supervision.
- annual review of the quality and safety of care.

The centre had implemented a key performance indicator report since the last inspection. The centre had completed an audit of slips, trips and falls, including an analysis of the times of the incidents. An infection control audit had also been recently completed. Inspectors reviewed the monthly key performance indicator report available for March 2016. This included the monitoring of a number of different areas including dependency levels, pressure ulcers and wounds, restraint, falls, weight loss and infections in the centre. However the information in this report was not accurately reflecting the number of residents with bed rails in place as outlined in outcome 7, or all of the residents who had experienced significant weight loss.

The management system in place in the centre was ineffective in that actions necessary

to address non-compliances identified in outcomes 2,5,7,8,9,11 and 18 during the previous inspection of the centre in November 2015 had not been satisfactorily implemented. The system of staff supervision was inadequate as outlined in outcome 18. The management of the individual units/floors required improvement, as had been found at the previous inspection in the centre in November 2015. There was no identifiable nurse responsible for the overall management on each floor to ensure effective supervision of the care being delivered on an on-going basis, and to ensure effective management of the unit/floor. The system in place meant that the person in charge and the assistant director of nursing were responsible for all clinical auditing, and the overall management of the centre including the local management of each floor. This lack of management resources was impacting on the delivery of care to the residents.

The system in place to monitor the service being provided within the centre was ineffective as reflected by the findings in outcomes 7,8,9,11,15 and 18. Management in the centre had not completed a recent comprehensive audit of medication management in the centre as outlined in outcome 9, to include review of administration practices and the prescription sheets and administration records. There was no effective system in place to ensure that all nursing staff were reporting and documenting medication related incidents including omissions in documentation of administration of medicines as outlined in outcome 5. Lack of effective comprehensive clinical audit was also evident from the findings related to wound care, use of bed rails, management of nutrition and nursing documentation such as care plans.

The preparation of an annual review for the centre had commenced, and contained information on occupancy and the quality improvement plan for the centre including the purchase of new equipment. Resident satisfaction surveys had also been completed as part of the consultation process with residents and their families. However the annual review required further input to ensure that the review process included analysis of the quality and safety of care delivered to residents to ensure that such care was in accordance with the standards.

Judgment:
Non Compliant - Major

***Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

Theme:
Governance, Leadership and Management

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

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

Findings:

The aspects of this outcome reviewed during the inspection included the areas of non-compliance identified during the last inspection of the centre in November 2015.

The medical records had been transferred and were now available on each floor stored with residents' care plans and other relevant documentation. Nursing and medical notes reviewed by the inspectors were found to be organised in chronological order.

The daily records completed by nursing staff were found to vary considerably in that the majority did not outline the full range of care and treatment provided to residents, while some entries in the daily progress notes did provide sufficient detail.

As outlined in outcome 9 inspectors identified a number of issues on medication administration records maintained in the centre including:

-there was no documented administration of one medicine prescribed for one resident to treat epilepsy for 7 days. The administration records were blank for this time period with no documented explanation. The medication administration records for a medicine used to treat diabetes had not been recorded as being administered for a number of days. Similarly there was no documented administration of an antibiotic prescribed for one resident for a number of days, and of a once weekly medicine used to treat osteoporosis.

The policy on the protection of vulnerable adults and procedures on abuse had been updated and did reference national policy and procedures as outlined in 'safeguarding vulnerable persons at risk of abuse'. However the policy was not sufficiently detailed to ensure an appropriate consistent response to allegations of abuse, with sufficient information regarding the process of screening and investigation of all such allegations.

Staff rosters had been updated to reflect the hours worked by staff, but there was still some inconsistencies regarding the exact hours worked by some staff on some rosters reviewed by the inspectors. The staff rosters for night staff were not sufficiently detailed to indicate the allocation of staff working on each floor.

Judgment:

Non Compliant - Moderate

Outcome 07: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe care and support

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

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

Findings:

The aspects of this outcome reviewed during this inspection included the areas of non-compliance identified in the centre during the last inspection in November 2015.

Inspectors reviewed the management of responsive/challenging behaviours in the centre. A number of staff had received training in the management of these behaviours in March 2016. Inspectors reviewed a sample of the care plans in place and found that these plans contained sufficient detail to enable staff to respond to such behaviours in a consistent appropriate manner.

Inspectors were informed that the total number of residents with bed rails in place had been reduced since the last inspection. Restraint was included on the monthly key performance indicator audit conducted in the centre. However this audit did not accurately reflect the number of residents with bed rails in place. Inspectors noted that a number of residents with bed rails in place while in bed were not included on the most recent key performance audit made available on the day of the inspection. Inspectors found that documented bed rails assessments were not in place for all residents with bed rails in place. Inspectors found that there were no care plans in place to guide staff in their use in a safe consistent manner. The bed rail risk assessments reviewed by inspectors did not contain information on alternatives trialled to provide evidence that less restrictive alternatives had been considered and/or trialled.

Judgment:

Non Compliant - Major

Outcome 08: Health and Safety and Risk Management

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

Theme:

Safe care and support

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

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

Findings:

The actions required from the previous inspection were found to be largely addressed or in the process of being addressed with the exception of the issue of fire drills.

On the previous inspection, it was found that there was no risk register in place. It was found on this occasion that a risk register had been created for the centre on a unit by unit basis. The inspector observed that this was documented as having been completed

in December 2015 and was scheduled for review in April 2016.

On the previous inspection, it was found that the training records indicated that not all staff had received fire safety training. The inspector noted on this occasion that fire safety training had been delivered to staff in January 2016.

On the previous inspection, it was found that the records for fire drills did not adequately demonstrate that staff members were aware of the procedures to evacuate residents in the event of a fire. It was found on this occasion that while there was improvement in the level of detail recorded in relation to drills and that they were being conducted regularly; further improvement was required in a number of respects. The drill procedure as described to the inspector and documented on the records did not adequately replicate real life fire scenarios, staffing levels or simulate any evacuation of fire compartments. Furthermore, there were no adequate arrangements in place to ensure permanent night staff could participate in fire drills as they were conducted during the day.

On the previous inspection, it was found that there was limited availability of assistive equipment to assist in the evacuation of requirements. On this inspection it was found that a supply of ski sheets had been purchased to allow residents with limited or no mobility to be evacuated in a timely fashion in the event of a fire at night within the centre. The service was in the process of assessing each resident to establish their needs in the event of an evacuation in order to ensure residents requiring assistive equipment were provided with same, although this had not been completed on the date of the inspection.

In addition to following up on the actions arising from the previous inspection as described above, on this inspection, the fire safety management arrangements for the centre were reviewed in detail, including the physical fire precautions in place. The arrangements for maintenance of same as well as the fire and evacuation procedures were also examined.

The inspector found the building in which the centre was located was equipped with the necessary equipment to ensure the safety of residents in the event of a fire. The building was noted as having been purpose built and of traditional masonry construction.

There were an adequate number of escape routes and these were observed as being clear from obstruction on the date of inspection. The centre was extensively divided with fire resistant construction to contain a fire and prevent the movement of heat and smoke throughout the building. The inspector observed that fire resistant doors had been provided throughout the building. Upon closer examination, it was found that while the provision of fire resistant doors was extensive, remedial action was required in a number of cases to ensure that the doors could perform effectively in the event of a fire. Numerous fire resistant doors were identified with damage that would affect their performance, such as damage to the fire / smoke seals provided around the perimeter of the door, and also self closing devices which at either been damaged or disabled through disconnection or the use of wedges. It was also noted that the fire resistant doors fitted to the bedrooms were not equipped with self closing devices. Many of these

doors were observed as being left open or ajar throughout the inspection.

The centre had a small number of residents who smoke, and to that end, a smoking room was provided for their use. This room was provided with a fire extinguisher and a fire resistant door. The furniture within was largely upholstered and in some instances, the filling material was exposed due to the presence of holes in the cover material which is contrary to good practice in such rooms due to the potential flammability of filling material.

The centre was provided with a fire detection and alarm system throughout. The system was able to display the location of the detection within the centre. The location was displayed on the main fire alarm panel located at reception, as well as numerous secondary or slave alarm panels provided at nurse stations throughout the building. It was also displayed on pager devices carried by some staff within the centre. The system also triggered the closure of numerous fire resistant doors throughout the centre. These features were demonstrated to the inspector by maintenance personnel. The centre was provided with an emergency lighting system. The centre was also provided with first aid fire fighting equipment in the form of fire extinguishers and fire hose reels throughout.

With respect to fire safety maintenance arrangements, the inspector found areas of good practice but also identified areas where improvements were required. With respect to maintenance by external personnel, it was found that the fire alarm system had been serviced as required. The fire extinguishers were also serviced as required, although the extinguisher in the smoking room had not been serviced as required according to the inspection table affixed to the extinguisher body. While the emergency lighting was inspected annually by a contractor, it was not inspected every three months as prescribed in the Irish standard covering emergency lighting.

There were weekly fire safety checks carried out by onsite maintenance personnel, which checked the fire detection and alarm system and door closing devices. While this was good practice, the checks were not of adequate extent or detail to ensure all fire safety features within the building are functioning correctly on an ongoing basis. The findings already described relating to damaged or disabled fire doors and the upholstery in the smoking room indicated that the system of fire safety checks required review to ensure they were of adequate extent, frequency and detail. The inspector also spoke to laundry and kitchen staff and found them knowledgeable as to what constituted good fire safety practice in their roles.

The inspector found that there was a fire and associated evacuation procedure in place within the centre. While being displayed throughout the centre, it required review to ensure that procedure could be executed in a timely fashion at all times within the centre for all possible scenarios, including at night time. For certain fire scenarios, the person responsible for coordinating the response may not be immediately available thus constituting an unnecessary delay in the execution of the procedure in the event of a fire. The identity of people with roles imperative for coordinating the procedure were not clearly outlined, particularly at night time. The means of communication within the centre referred to within the procedure was also not clear. It was also noted that two formats of fire procedure notices were displayed throughout the centre and it was not clear from review how the two notices corresponded with each other.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

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

Theme:

Safe care and support

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

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

Findings:

The aspects of this outcome reviewed during inspection included the areas where non-compliances had been identified during the previous inspection on 12/11/2015.

Inspectors reviewed a number of prescription and administration sheets. The centre had started the process of implementing a new prescription sheet which addressed a number of the issues identified previously. The new prescription sheets included details of residents' allergies, the authorisation to crush medicines on each line of the prescription sheet, indications for the administration of PRN (as required) medicines, maximum doses of PRN medicines, and space for the prescriber to document the last medication review. However inspectors noted that the following issues which had been identified during the last inspection had not been addressed on all prescription sheets: -original prescription sheets were not in place for all residents (photocopies were being used).

-a number of the prescription sheets did not indicate if the resident had allergies to any medicines or no known allergies.

-there were no indications for all PRN (as required) medicines to indicate the circumstances in which the medicines were to be administered to ensure consistent administration by staff.

Inspectors also noted that dates of opening were not being consistently recorded on all opened nutritional supplements to ensure that these supplements were not administered to residents after the specified expiry period.

Inspectors identified a number of issues on medication administration records maintained in the centre including:

-there was no documented administration of one medicine prescribed for one resident to treat epilepsy for 7 days. The administration records were blank for this time period with no documented explanation. The medication administration records for a medicine used to treat diabetes had not been recorded as being administered for a number of days. Similarly there was no documented administration of an antibiotic prescribed for one resident for a number of days, and of a once weekly medicine used to treat osteoporosis. This finding is included under outcome 5.

-One resident had been prescribed an eye drop to treat glaucoma, however there were no recent administration records to confirm that this medicine had been administered as prescribed.

Nursing staff could not account for these discrepancies on the day of the inspection, and there was no system in place to ensure that such discrepancies were identified as medication related incidents and appropriately reported and documented to ensure adequate investigation.

-Printed medication administration sheets specifically printed for one resident with a photograph, allergy details and doctor details were being used to record the administration of medicines to another resident with the original resident's name crossed out in pen.

A pharmacist from the retail pharmacy business supplying medicines to the centre had provided medication management training to a number of the nursing staff. An audit of aspects of medication management practice had also been conducted by the pharmacist. However management within the centre had not completed a recent comprehensive audit of medication management in the centre including administration practice and review of prescription and administration sheets to ensure medication management in the centre was safe, appropriate and consistent. This finding is included under outcome 2.

The person in charge provided assurance to the inspectors that the issues raised regarding medication management in the centre would be addressed.

Judgment:

Non Compliant - Major

Outcome 10: Notification of Incidents

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

Theme:

Safe care and support

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

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

Findings:

A record of all incidents occurring in the designated centre was maintained and where required notified to the chief inspector.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of

evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:

Effective care and support

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

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

Findings:

The aspects of this outcome reviewed during the inspection included the non-compliances identified during the previous inspection in November 2015.

Inspectors found that practice had improved in certain areas since the last inspection. Staff had received training in managing incontinence, and extra sliding sheets had been purchased to ensure appropriate manual handling practice. The centre planned to implement an electronic documentation system. However practice in relation to wound care, monitoring body weights and nutrition required further improvement.

The documentation in relation to wound management was not sufficiently detailed to evidence a high standard of evidence based nursing care. The inspectors reviewed nursing documentation relating to wound care for one resident. The resident had been reviewed by the tissue viability nurse who had recommended that the dressing was changed every second day. However there was not always documented evidence that this dressing was changed at the required frequency. Poor care practice in relation to wound care had been identified during the previous inspection in November 2015. Inspectors found wound care records including records for the management of leg ulcers were incomplete. Wound assessment forms and wound care plans reviewed on this inspection for residents with wounds did not reflect the status of the wound, the type of dressing being used and or the frequency at which the wound was to be dressed.

Inspectors noted that a number of residents' care plans had not been updated within the four month time period as specified in the regulations. A number of nutritional care plans had not been updated to reflect recommendations from allied health care professional such as dieticians. This had been a finding during the previous inspection in November 2015. One resident who had been identified as being at risk of malnutrition, was not being weighed on a monthly basis despite recommendations from the dietician to complete monthly weights. Residents were not routinely weighed on a monthly basis and the nutritional care plans in place did not consistently indicate the frequency at which residents should be weighed. On one of the units the dietician had recommended that two residents should receive fortified diets. However the diet list maintained in the kitchen on that floor did not contain recommendations to fortify any of the residents' meals, and staff spoken to by the inspector confirmed that none of the residents on the unit were having their meals fortified. This finding is included under outcome 15.

Judgment:

Non Compliant - Moderate

Outcome 15: Food and Nutrition

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.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The aspects of this outcome reviewed during the inspection included the systems in place to ensure residents received appropriate assistance at meal times, and that residents with specialised diets had their specific needs met.

Inspectors observed lunch being served to residents in a number of the units. Residents could have their lunch served in the dining areas in the units, downstairs in the main ground floor dining area or in their bedrooms if they preferred. Inspectors observed that there were staff present at all times while lunch was being served, and that residents who required assistance were provided with such assistance in an appropriate manner.

The food was prepared in the main kitchen and transferred to each of the dining areas. Lists were maintained of the residents who required modified consistency diets, to enable staff in each of the dining areas to properly prepare the food for serving. On one of the units the dietician had recommended that two residents should receive fortified diets. However the diet list maintained in the kitchen on that floor did not contain recommendations to fortify any of the residents' meals, and staff spoken to by the inspector confirmed that none of the residents on the unit were having their meals fortified.

Judgment:

Non Compliant - Moderate

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People)

Theme:
Workforce

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

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

Findings:

Inspectors reviewed the staffing levels in the centre at the time of the inspection. Staffing levels had not changed since the last inspection in November 2015. During the last inspection inspectors found that the skill mix of staff was not appropriate to meet the needs of the residents. Inspectors also found that the system of supervision in place was not appropriate. These two non-compliances had not been satisfactorily addressed.

Inspectors were informed that the centre had advertised for a clinical nurse manager and for nursing staff and that this recruitment process was on-going, but at the time of the inspection a clinical nurse manager had not been recruited. Nursing staff had been recruited but a number of nursing staff had also resigned so the centre planned to continue advertising for more nursing staff. There was no evidence that the number and skill mix of staff had been reviewed to determine the appropriate levels and skills mix to meet the assessed needs of the residents considering the size and layout of the centre. Inspectors did observe that at times there was a delay in staff responding to call bells. On one unit in the afternoon this delay was due to the fact that there was only one healthcare assistant available to respond to the call bell, and when the call bell was activated the health care assistant couldn't respond as they were assisting a resident with personal care. Information had been received by HIQA in relation to residents having to wait for considerable times before call bells were answered.

There was only one registered nurse rostered to work on each of the three floors at any one time. The nurses' time was taken up with tasks such as administering medications, completing wound dressing, organising referrals to the allied health care team and completing clinical documentation. The lack of an appropriate skill mix was also resulting in poor standards of clinical documentation, and in relation to aspects of healthcare as outlined in outcome 11. The care being provided was not being supervised by a qualified staff nurse on a consistent basis. Sisters from the congregation also worked on each of the units and health care assistants routinely reported to the Sisters.

There was also lack of supervision and clinical oversight at unit/floor level, as indicated by the findings outlined in outcomes 7 on safeguarding, outcome 9 on medication management and outcome 11 on healthcare.

The hand over system had been changed since the last inspection, but the work patterns and communication between staff on each floor required further improvement. Inspectors found that staff were not working together as a team at all times. Staff nurses and carers/Sisters were observed to work independently of each other, as there was only one nurse on duty on each floor, and two of the floors consisted of two units. The manner in which staff handovers were organised reflected this segregation of staff,

and involved a number of hand over meetings between the nursing staff, the nursing staff and the Sisters from the congregation who worked on the units, and the nursing staff and the assistant director of nursing and person in charge. There was no hand over meeting between the nursing staff and the health care assistants. The assistant director of nursing had started to produce a daily report for the person in charge at the end of each day regarding resident specific issues.

There was a human resources system in place to enable management to review mandatory training requirements and track all staff training. The records reviewed indicated that no training on elder abuse or protection of vulnerable adults had taken place in the centre since November 2015 to ensure that new staff members who had started working in the centre within the last four months had received the required training.

Judgment:
Non Compliant - Major

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Jim Kee
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Sacred Heart Residence
Centre ID:	OSV-0000157
Date of inspection:	05/04/2016
Date of response:	17/05/2016

Requirements

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

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

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The centre did not have sufficient management resources to ensure the effective delivery of care.

1. Action Required:

Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

purpose.

Please state the actions you have taken or are planning to take:

We have arranged for one of our nurses to act up in the role of clinical nurse manager until we have recruited a person for a permanent position in this role.

We are increasing the number of nurses on day duty so that a nurse will now be rostered to supervise the care of staff and residents on the John Vianney and Dom Marmion's units.

We continue to advertise for clinical nurse managers and have made contact with a recruitment agency to source candidates for the position of clinical nurse manager. Commencing Monday the 23rd May, the acting CNM will manage the three floors.

We will change the handover procedures in the centre so that a handover occurs between the nurses and healthcare assistants on each unit on commencement of the day shift. A midday 'huddle' will take place between the nurses and healthcare assistants to share information about the care and condition of residents since the commencement of the shift. A night time handover will take place between the nurse going off duty and the nurse and healthcare assistants coming on duty at the end of the day shift.

Standard documentation will be used for handover and include a record of any events, incidents, changes in residents' condition. These reports will be given to the CNM who will follow up with staff on each unit to ensure that appropriate actions are taken in response to any events, incidents or changes in a resident's condition. The CNM will also follow up with nursing staff on a day to day basis to ensure that records and care plans are updated in accordance with residents' changing needs.

The CNM will attend the morning handover in one of the units and the midday 'huddle' in another unit each day as a means of supervising and directing staff.

We have reviewed roles and responsibilities of all grades of staff with external consultants and have a plan to restructure the roles and responsibilities of healthcare assistants to ensure that they are fully involved in providing care and supervision to residents.

From Monday 23rd May, the Assistant Director of Nursing will assume responsibility for collating data for KPIs and carrying out audits in accordance with the audit programme for the centre-more detail on this is provided in the next section.

We will furnish details of the plan for restructuring roles and implementation of same once completed.

Proposed Timescale: 13/07/2016

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

-The management system in place in the centre was ineffective in that actions necessary to address non-compliances identified in outcomes 2,5,7,8,9,11 and 18 during the previous inspection in November 2015 had not been satisfactorily implemented.

-the system in place to monitor the service being provided within the centre, including the system of clinical auditing was ineffective as reflected by the findings in outcomes 7,8,9,11,15 and 18.

-the management of the individual units/floors was not adequate to ensure effective supervision of care and to ensure effective management of the unit/floor.

2. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:

Establishment of a clinical governance system for continuous quality improvement for the Sacred Heart Nursing Home. This system will be based on the 18 outcome framework and will include:

- Establishment of a clinical governance committee for the home.
- Proactive collection of data on quality and safety indicators.
- Trending and analysis of quality indicators on a monthly basis.
- Development of clinical governance action plans to address issues arising from monitoring quality and safety data.
- Dissemination of learning and making improvements based on monitoring of quality and safety data.

Develop a clinical governance policy to outline the system being implemented and to ensure that staff have the required guidance to implement the system in place.

Mentoring for the clinical governance committee has been arranged.

Develop an audit programme for the Centre to identify areas for improvement; measure improvement and monitor improvements. This will be achieved by:

- Identifying 'external must do' audits based on requirements of national standards and regulations.
- Use of metrics to be completed on a scheduled basis.
- Use of a priority matrix tool to identify and prioritise areas / topics for audit according including internal 'must do' audits identified from clinical governance activities.
- Develop audit tools for priority / must do audits to include environmental hygiene, hand hygiene; medication management, care planning; bedrail use; restraint use; tissue viability; falls prevention and management; nutrition.

Provide training to designated staff on completion of audits.

Proposed Timescale: 24/06/2016

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The annual review did not include an analysis of the quality and safety of care delivered to residents to ensure that such care was in accordance with the standards.

3. Action Required:

Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:

An annual review of the centre against the national standards and regulations has been undertaken with the assistance of external consultants. This review is being used to develop our clinical governance action plan for the centre.

Proposed Timescale: 20/05/2016

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The policy on the protection of vulnerable adults and procedures on abuse was not sufficiently detailed to ensure an appropriate consistent response to allegations of abuse, with sufficient information regarding the process of screening and investigation of all such allegations.

4. Action Required:

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:

We will revise and amend our policy on safeguarding to ensure that it provides sufficient details on the procedures for recognising, reporting and responding to elder abuse.

Mentoring has been arranged for the management team on record-keeping and completion of investigations in accordance with the National Safeguarding Policy (HSE, 2014)

Proposed Timescale: 17/06/2016

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

- Staff duty rosters did not consistently indicate the exact hours worked by all staff, including allocation of staff at night.
- The daily records completed by nursing staff were found to vary considerably in that the majority did not outline the full range of care and treatment provided to residents.
- Accurate contemporaneous records of each medicine administered as specified in schedule 3 of the regulations were not consistently maintained in the centre.

5. Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:

The hours of all staff and sisters working on the unit are now included in the rosters.

We have arranged for a 5 day training / mentoring programme for staff nurses on assessment and care planning, including completion of daily records.

We have informed staff nurses of the finding of the inspection with regard to recording medicines administered. As part of the audit programme for the centre, the medication management audit will include administration sheets.

Medication management education sessions for nursing staff have been arranged for the 31st May 2016.

A new daily care and handover sheet for healthcare assistants will be introduced to assist in the recording of care given by healthcare assistants, which will be used by nursing staff for completion of their daily records.

Proposed Timescale: 13/07/2016

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There was not always documented evidence of the trial/consideration of alternatives to ensure the use of bed rails was in accordance with national policy. In some cases there were no documented bed rail assessments in place.

6. Action Required:

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a

designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

Please state the actions you have taken or are planning to take:

A review and audit of bedrails in use has been arranged. This will be completed with the assistance of an external consultant in order to mentor the assistant director of nursing in completion of same.

As part of the care planning mentoring programme nurses will have training on assessment and care planning for residents, where restraint interventions are being considered.

Training for all nursing and care staff on the use of restraint has been arranged, This training will include the use of bedrail in accordance with the National Policy (DOHC, 2011).

Proposed Timescale: 13/07/2016

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The programme of fire drills in place did not assure inspectors that all staff are fully aware of the procedures to follow in the event of a fire for the following reasons:

Real life fire scenarios, while discussed as part of the drills, were not simulated.

No evacuation was simulated as part of the fire drills.

There were no adequate arrangements in place to ensure all staff, including night staff, participated in the fire drill programme.

7. Action Required:

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:

We engaged an external consultant to carry out a fire risk assessment for the centre and advice on actions required. This risk assessment looked at all aspects of fire prevention and protection.

The fire procedure will be revised and updated to ensure that they provide details required as identified by the inspection.

Additional fire training will be provided to staff to ensure that all staff are familiar with the procedure.

Fire drills will be carried out to ensure that staff respond appropriately to the fire alarm.

Proposed Timescale: 01/07/2016

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The process of assessing each resident to establish their needs in the event of an evacuation in order to ensure residents requiring assistive equipment were provided with same, while in progress, was not complete on the date of the inspection.

The fire procedure required review in order to ensure it could be executed in a timely fashion at all times within the centre for the reasons outlined within the findings.

8. Action Required:

Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

Please state the actions you have taken or are planning to take:

The personal emergency evacuation plans for each resident will be completed in accordance with the changes to the fire procedure.

The fire procedure will be revised and updated to ensure that they provide details required as identified by the inspection.

Proposed Timescale: 01/07/2016

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The fire safety maintenance arrangements in place were not adequate in the following respects:

A number of fire resistant doors were not maintained in a manner that would ensure they could perform effectively in the event of a fire as described within the findings.

The upholstered furniture within the smoking room was not adequately maintained.

One fire extinguisher was identified as not being serviced as required according to the

inspection table affixed to the body of the extinguisher.

The emergency lighting was not inspected on a quarterly basis in the manner prescribed within the relevant technical standard.

The system of in house fire safety checks required review to ensure they were of adequate extent, frequency and detail.

9. Action Required:

Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

Please state the actions you have taken or are planning to take:

We engaged an external consultant to carry out a fire risk assessment for the centre and advice on actions required. This risk assessment looked at all aspects of fire prevention and protection. The fire doors will be checked and the issues identified in the inspection report will be addressed.

The provision of fire resistant doors within the centre will be reviewed and remedial action taken where necessary to ensure that the doors are capable of performing effectively in the event of a fire.

The upholstery in the furniture in the smoking room will be addressed to ensure that it is compliant with fire safety requirements.

The fire extinguisher identified will be serviced.

Emergency lighting will be inspected and a system put in place to ensure it is inspected quarterly in accordance with standards,

We have arranged with the external consultant to develop a robust fire register in the centre that will include a standard schedule of in-house fire safety checks for fire prevention and fire safety equipment, the environment and procedures. The completion of the checks included in the register will be designated to individual members of staff. We will include fire safety audits in the audit programme for the centre.

Additional fire training will be provided to staff to ensure that all staff are familiar with the procedure.

Fire drills will be carried out to ensure that staff respond appropriately to the fire alarm.

Proposed Timescale: 13/07/2016

Outcome 09: Medication Management

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

-One resident had been prescribed an eye drop to treat glaucoma, however there were no recent administration records to confirm that this medicine had been administered as prescribed.

A number of the prescription sheets in use within the centre did not contain all required information as required

-original prescription sheets were not in place for all residents (photocopies were being used).

-a number of the prescription sheets did not indicate if the resident had allergies to any medicines or no know allergies.

-there were no indications for all PRN (as required) medicines to indicate the circumstances in which the medicines were to be administered to ensure consistent administration by staff.

10. Action Required:

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:

All nursing staff will attend medication management refresher training to ensure they are familiar with professional codes and the recent provider guidance (HIQA, 2015).

A standardised prescription sheet will be introduced, which will include the allergy status of each resident and all of the requirements of the HIQA, 2015 provider guidance and legislation.

We will liaise with the prescribers to request that indications for 'prn' medicines are recorded on the prescription sheets.

As outlined previously, medication management audits will be carried out as part of the audit programme for the centre.

Proposed Timescale: 08/07/2016

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Dates of opening were not being consistently recorded on all opened nutritional supplements to ensure that these supplements were not administered to residents after the specified expiry period.

11. Action Required:

Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no

longer be used as a medicinal product.

Please state the actions you have taken or are planning to take:

Nurses have been informed of the need to record the date of opening of oral nutritional supplements.

As previously stated we will review our medication management processes to ensure that all process are robust.

Proposed Timescale: 08/07/2016

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Inspectors found that care plans were not consistently updated with recommendations from allied healthcare professionals. A number of care plans in place were not sufficiently detailed to guide care. Care plans were not consistently reviewed at intervals not exceeding four months.

12. Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

Please state the actions you have taken or are planning to take:

As previously outlined, We have arranged for a 5 day training / mentoring programme for staff nurses on assessment and care planning, including completion of daily records.

Proposed Timescale: 13/07/2016

Theme:

Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Documentation to confirm that care related to wound management and nutritional management had been provided as specified in the relevant care plans and as per the recommendations of allied health care professionals was not consistently present.

13. Action Required:

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident,

including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:

As previously outlined, We have arranged for a 5 day training / mentoring programme for staff nurses on assessment and care planning, including completion of daily records.

Proposed Timescale: 13/07/2016

Outcome 15: Food and Nutrition

Theme:

Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The system in place to ensure all residents received fortified meals as recommended by the dietician was not adequate.

14. Action Required:

Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

Please state the actions you have taken or are planning to take:

The CNM will be responsible for checking the diet sheets of residents on a daily basis to ensure that they are correct and to ensure that the information related to residents needs for fortification and / or modified diets are recorded on these sheets and a copy given to the catering and the dining areas for healthcare assistant staff providing assistance to residents at mealtimes.

Proposed Timescale: 25/05/2016

Outcome 18: Suitable Staffing

Theme:

Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The skill mix of staff was not appropriate for the size and layout of the centre to ensure residents' needs were met. The staffing levels and skill mix had not been reviewed to determine the appropriate staff numbers and skills mix to meet the assessed needs of the residents considering the size and layout of the centre.

15. Action Required:

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:

A review of the staffing numbers and skill mix of the centre has been completed. A copy of same is attached for the inspectorate to view. Recommendations identified in the staffing review will be implemented which include the recruitment of a clinical nurse manager and additional registered nurses.

The roles and responsibilities of unit sisters, healthcare assistants, cleaning and catering staff will be reviewed in order to restructure their roles so as to ensure that the resident's care and supervision needs are met, while at the same time ensuring that the environment is kept clean and safe.

We have made contact with a recruitment consultant to recruit nursing staff and a clinical nurse manager.

In the interim, an acting clinical nurse manager will commence duty on the Monday 23rd May.

Proposed Timescale: 13/07/2016

Theme:

Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The system of supervision in place for all staff was not adequate to ensure appropriate levels of care was being delivered at all times.

16. Action Required:

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

Please state the actions you have taken or are planning to take:

As outlined above, a nurse has commenced acting in the position of clinical nurse manager until a clinical nurse manager can be recruited.

The acting CMN will manage the units and supervise nursing and care staff.

Staff handover will now be carried out for nurses and healthcare assistants together in the mornings and evenings.

A midday 'huddle' will take place where nurses and healthcare assistants will feedback to the team on the care and conditions of the residents.

Healthcare assistants will complete a daily care and handover sheet to provide feedback to nursing staff.

Roles and grades are being reviewed so as to ensure that healthcare assistants spend their time on the residents care under the direction and supervision of the nurses.

A policy on delegation and supervision will be developed and provide guidance to nursing staff on same.

Proposed Timescale: 13/07/2016