Sacred Heart Hospital inspection report, 3 April 2012

Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

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

Centre name:	Sacred Heart Hospital
Centre ID:	0648
Centre address:	Pontoon Road Castlebar Co. Mayo
Telephone number:	094-9021122
Fax number:	094-9026055
Email address:	michael .fahey@hse.ie
Type of centre:	☐ **Private** ☐ **Voluntary** ☒ **Public**
Registered providers:	Health Service Executive
Person in charge:	Mary Cotter
Date of inspection:	03 April 2012
Time inspection took place:	**Start:** 10:00 hrs **Completion:** 17:30 hrs
Lead inspector:	Catherine Connolly-Gargan
Support inspector:	PJ Wynne
Type of inspection:	☐ Announced ☒ Unannounced
Purpose of this inspection visit:	☐ Application to vary registration conditions ☐ Notification of a significant incident or event ☐ Notification of a change in circumstance ☐ Information received in relation to a complaint or concern ☒ Follow-up inspection

About the inspection

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

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

Additional inspections take place under the following circumstances:

- to follow up matters arising from a previous inspection to ensure that actions required of the provider have been taken
- following a notification to the Health Information and Quality Authority's Social Services Inspectorate of a change in circumstance for example, that a provider has appointed a new person in charge
- arising from a number of events including information received in relation to a concern/complaint or notification to the SSI of a significant event affecting the safety or wellbeing of residents
- to randomly "spot check" the service.

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

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

About the centre

Description of services and premises

The Sacred Heart Hospital is a single-storey building which commenced operation on the 30 of October 1973. The centre provides accommodation for up to ninety residents mainly over 65 years of age. Residents with dementia, acquired brain injury and intellectual care needs are also currently accommodated in the centre some of which are under 65 years of age. In addition to the older person services, there is also a busy day-care service with a separate facilities and Physiotherapy, Occupational therapy and Social Work departments. A separate rehabilitation unit consisting of 36 beds is located in the centre and admits patients from the acute services for rehabilitative care back to the community.

The designated centre for long term care services is nestled amidst the other services but consists of three designated units which are St John's, St Anthony's and Our Lady's Units. St John's unit was refurbished and extended in 2010 and provides accommodation for a maximum of 35 male residents. Our Lady's unit accommodates up to 35 female residents. St Anthony's unit has accommodation for a total of 20 male and female residents. Accommodation within the three units is mainly in multi-occupancy four to six bedded rooms. There are eight single rooms with en suite, toilet, hand-washing and shower facilities between the three long term care units. Each unit had a kitchenette and dining/sitting room. Other facilities in the centre include a hairdressing salon, reminiscence room, sitting areas at the front door, a large conservatory sitting area, a recreational/art room and two small sitting areas located off the centres main corridors. The residents also have access to a large church attached to the centre and accessible from the centre.

The reception is staffed each weekday up to five o'clock. It is located near the entrance in a spacious lobby which contains a variety of seated areas and vending machines.

Car parking was available close to the main entrance.

Location

The centre is located on the Pontoon road, within walking distance of Castlebar town centre. A footpath leads from the centre to local shops and businesses.

Date centre was first established:	30 October 1973
Number of residents on the date of inspection:	82 + 2 in hospital and 1 on holiday
Number of vacancies on the date of inspection:	5

Dependency level of current residents	Max	High	Medium	Low
Number of residents	75	3	3	1

Management structure

Sacred Heart Hospital comes under the auspices of the Health Service Executive, West. The Person in Charge is Mary Cotter, Director of Nursing, who reports to Michael Fahey, nominated Provider and Manager of Older Person Services in Mayo.

Within each of the units there are a clinical nurse managers grade two and one who are responsible for overseeing the delivery of care and report to the assistant director of nursing (now vacant) and the director of nursing.

The catering, maintenance, laundry, allied health professionals and administration staff report through their professional line managers the nominated provider.

Staff Designation	Person in Charge	Nurses		Care Staff	Catering staff	Cleaning and Laundry staff	Admin	Other staff
Number of staff on duty on the first day of inspection	1 CNM deputising for the Person in Charge *The Person in charge	Our Lady's	I CNM2 4 nurses	3	3 chefs 12 catering assistants	1 supervisor 5 cleaning staff 1 laundry staff	5	3**
		St Anthony's	1 CNM1 2 nurses	2				
		St John's	1 CNM2 3 nurses	3				

*The person in charge was on leave but came to the centre for some hours to assist with the inspection and accept feedback.
**1 activity coordinator, 1 driver and 1 chiropodist.
Residents also have access to three occupational therapists, four physiotherapists, and one social worker who are located on-site. A dietician three days per week. Maintenance staffs are also located onsite and attend the centre as requested.

Background

This inspection was completed to follow up on the agreed provider response to address the action plan developed from findings of a follow-up inspection of the centre on the 22 November 2011. This inspection was carried out as part of the Authority's inspection programme to check progress on any outstanding actions from previous inspections and to monitor compliance with the Health Act 2007(Care and Welfare of residents in Designated Centres for Older people) Regulations 2009 (as amended).

This centre has been inspected by the Authority on three previous occasions. The first inspection by the Health Information and Quality Authority (the Authority) was on the 29 September 2010 and is published on the Authority's website www.hiqa.ie The provider was issued with a report which contained 19 actions, the actions required address of risk management procedures, review of the quality and safety of care, incomplete statement of purpose, fire safety procedures and fire safety training and incomplete contracts of care. The physical environment did not ensure that residents' privacy and dignity needs were met and all residents were not facilitated to achieve optimum health or fulfilment and care planning was not person centred.

All staff had not received mandatory training required by the regulations, for example elder abuse prevention and moving and handling. Complaint procedures were not adequate and not all staff practice was supported and informed by policies and procedures.

On the 05 November 2010, the Authority requested further information relating to six incidents notified to the Authority in the summary of accidents and incidents for the quarter ending 31 October 2010. This information was satisfactorily returned in full on the 16 November 2010.

The second inspection on the 03, 04 and 05 May 2011 was an announced registration inspection which took place over three days, is also published on the Authority's website www.hiqa.ie. Inspectors found that in general sufficient attention had not been given to the action plan developed from the previous inspection in September 2010 as none of the actions were fully completed.

Areas requiring improvement included greater emphasis on residents reaching their maximum potential in terms of physical, psychological, social and spiritual well-being and implementation of person centred goal setting.

While, the person in charge and the provider were involved in the management of the centre, governance was weak in a number of areas such as admission processes. The medical officer for the centre is not involved in the decision to admit residents. The person in charge stated that the admissions process in the centre is the function of the person in charge following discussions with the clinical nurse managers. There was also evidence of a lack of cohesive service provision between all units

accommodating the centre's residents and with staff training on dementia care and support.

Six residents under 65 years of age with diverse needs were resident in the centre. There was little evidence of exploration of other placement options to ensure their needs were adequately met and that they were facilitated to enjoy the best possible health. For example, a resident required rehabilitation but was not accommodated on the rehabilitation unit, another young resident exhibited on-going challenging behaviour.

There was a high level of residents with complex medical conditions. Inspectors found there was a lack of speech and language assessment for residents with swallowing difficulties and access to chiropody for bed bound residents.

While residents' acute medical care needs were promptly met, the medical officer's hours were insufficient to meet the on-going needs of residents and three monthly reviews were not always completed.

There were few opportunities for creative or recreational fulfilment, particularly to those with resident's a cognitive impairment which resulted in residents sitting around for long periods without any form of stimulation.

Care planning, nutrition, falls management, wound management and end of life care and medication management all required review and improvement.

There was a significant lack of personal storage space, an insufficient number of toilets and bathing facilities to meet the needs of the residents as outlined in the report referencing the premises, and no call bell system in place in one of the units.

A meeting was held in Longford between the provider Mr Michael Fahy and the Authority on the 14 October 2011 to agree the provider response to the action plan and to discuss on-going unsatisfactory provider responses in relation to the structure and layout of the building. A Statement of Purpose was also requested.

The third inspection of the centre by the Authority was carried out on the 22 November 2011. It focused on the areas of practice that required improvement as set out in the Action Plan developed from findings at the centre's registration inspection on the 03, 04 and 05 May 2011.

The inspectors found that the provider and person in charge had started to address most of the actions outlined however; inspectors again found that progress had been slow, with four actions satisfactorily completed and twenty five actions partially completed to varying degrees. Some of the partially completed actions were still at a very early stage for example introduction of new care plans, deployment of staff and skill mix was still at negotiation stage. Resident numbers in the centre had reduced by ten beds and admissions for long-term care has ceased. However, these long term admissions have recommenced in January 2012.

The provider was met for a second and third time on the 08 and 29 February by the Authority to discuss the inadequate responses to address deficits in service provision

in relation to speech and language therapy and medical care. Inspectors were told that plans were in place to conduct assessment and swallowing clinics on the 9th, 16th and 23rd February which were completed. The Provider also advised inspectors that he had meetings with the medical officer which was also completed.

Summary of findings from this inspection

This inspection was an unannounced one day inspection to follow-up on progress with completing the action plan from the inspection of 22 November 2011. It was the fourth inspection of the centre by the Authority.

There was evidence of good progress with addressing the action plan developed from the findings of the last inspection in November 2011. There were a total of twenty four actions of which ten were completed to a satisfactory standard. Those actions still not completed were at an advanced stage and there was evidence that there was prioritization in completing these actions based on risk.

There have been ongoing issues about staffing levels in relation to the number and needs of residents accommodated in this centre. Since the 22 November 2011, the person in charge did not have a deputy to take charge of the centre in her absence. While there was a registered nurse on duty on each of the three units there was no registered nurse on duty in overall charge of the centre when the person in charge was not on duty. Following extensive negotiations, agreement was obtained where overall in charge responsibility for the centre was arranged.

Inspectors found that new care plan documentation had been introduced to improve assessment of need and care documentation. Staff education and training was put in place to support its introduction and inspectors found that this process had commenced.

Medication management was of an improved standard and met the legislative requirement. GP review had improved and access of residents to this service was revised and strengthened arrangements were put in place by the provider to ensure adequate medical cover at all times.

Most residents had improved recreational therapies provided as part of resident care package by nurses and carers who were facilitated to upskill in this area through an education and learning programme.

A comprehensive review of staffing levels had taken place. One unit (of four) was closed last year and St Anthony's Unit was reduced to 20 beds due to on-going challenges from staffing shortages. There was a more cohesive approach to the care of residents in the centre with evidence of greater collaborative practices evidenced in positive outcomes for residents such as the many committees set up to lead out and support staff on evidence based practices and procedures than on all previous inspections.

The provider forwarded a revised application for registration on the 24 February 2012 to accommodate ninety residents in the centre in the following format:

- St Anthony's Unit, twenty beds to accommodate male and female residents
- St John's Unit, thirty five beds to accommodate male residents only
- Our Lady's Unit, thirty five beds to accommodate female residents only.

However, the physical environment did not comply fully with the specifications of the *National Quality standards for Residential Care Settings for Older People in Ireland* to meet the needs of thirty five residents in Our Lady's Unit but was suitable to meet the needs of twenty residents as demonstrated on St Anthony's Ward.

While space in St John's Unit has been significantly extended, St Anthony's and Our Lady's Unit are of a similar size with many facilities in common, the layout of Our lady's Unit did not meet the needs of residents accommodated there. The layout and design of the multi occupancy rooms in the unit made it difficult to provide for residents' individual and collective needs in a meaningful way that enabled the promotion of values such as privacy and dignity.

Residents' needs in Our Lady's Unit were not met in relation to storage facilities for residents' personal clothing and equipment, dining facilities and adequate showering and toileting facilities.

The Action Plan at the end of this report identifies all the areas where mandatory improvements must be made to meet the requirements the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

1. Action required from previous inspection:
Revise the Statement of purpose to include all legislative requirements.

This action was satisfactorily completed.

Although some revisions were required on the day of inspection, the Statement of Purpose and Function document for the centre has since been revised to reflect the aspects of the service required. The provider and person in charge were aware that changes in the services needed to be reflected in the Statement of Purpose and that it should be made available to residents on admission and following any changes. The inspectors were told that the number of residents to be accommodated may alter from time to time in response to the changing needs, staff availability and alterations to the premises to improve the personal space available to residents.

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. A reviewed copy dated March 2012 has been forwarded to the Authority as agreed on the 11 April 2012 and meets the legislative requirements.

2. Action required from previous inspection:
Ensure that there is an appropriately qualified registered nurse on duty and in charge of the designated centre at all times and a record maintained of same

This action was satisfactorily completed.

A cohort of three clinical nurse managers grade two deputised for the person in charge while on planned and unplanned leave. The person in charge was on annual leave on the day of inspection and a designated clinical nurse manager deputised in the role and met with the inspectors on arrival. A duty rota was planned in advance detailing the clinical nurse managers with overall deputising responsibility on each day of the week including weekends. This rota was circulated to all units so all staff were aware who they should call if assistance or advice at that level was required. A larger cohort of staff nurses took overall responsibility for the centre while on duty. All staff with deputising arrangements continued to be unit based and with their usual workload commitments and responsibilities there. The person in charge was in process of developing a training document to assist staff in their critical thinking and decision making skills while in a deputising position. Interim updates had taken place which included review of the emergency plan for the centre.

3. Action required from previous inspection:
Using appropriate evidence based tools, review the staffing levels on day and night duty, taking into account the size and layout of the centre, the number of residents, their dependencies, their assessed needs and ensure that residents can be safely evacuated in case of fire.

This action was partially completed.

The person in charge discussed the dependency/staffing tool referenced for staffing level and skill mix review. The provider told inspectors that the staffing moratorium was presenting a significant challenge to maintaining staffing levels and skill mix in the centre. The person in charge did not have a designated person to deputise in her absence up to the last inspection but inspectors noted that this has since been progressed and arrangements were now in place to address this deficit safely.

The senior management structure was also strengthened with the rostering of a clinical nurse manager on duty each weekend. Additional health care assistants have been deployed to care duties in the centre. The number of residents in one unit had been reduced to twenty on a permanent basis to ensure their needs were met by the available staffing levels and skill mix. Inspectors noted that residents in this unit were well supervised and were involved in recreational activities.

However inspectors noted that seven residents in assistive and wheel chairs were unsupervised for prolonged periods in the sitting room of St Johns Unit which was the largest of the units. Although there was eight staff on duty they were busy attending to residents in other areas of the unit at this time. Inspectors noted that 28 (80%) of the residents in this unit had assessed maximum dependency needs. These findings may indicate that staffing levels and skill mix required further review in this Unit.

Aspects of this action not completed to a satisfactory standard are restated in the action plan at the end of this report.

4. Action required from previous inspection:
Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.

This action was partially completed.

Inspectors noted that progress had been made with this action since the last inspection and although not completed was advancing well. Six key staff, clinical nurse managers attended auditing training on the 26 March 2012. An auditing plan was been developed which would be finalised on the 16 of April 2012.

A weekly audit of key practice indicators was collated on each unit and forwarded for the attention of the person in charge, for example, staffing absences, resident illnesses/falls and hospital admissions, pressure sores, new residents admitted to the centre, adverse incidents and complaints. The person in charge had commenced auditing this global data.

Clinical nurse managers at unit level who had done specialist courses such as restraint management and infection control were leading out on auditing key quality indicators in these areas such as handwashing, and restraint use.

Other areas in the plan for review included nutritional intake and medication management. Opportunity was availed of to share findings of audits.
The information from audits and progress with quality improvement initiatives was communicated and discussed at staff meetings and at shift handover and management meetings. Although planned but as yet awaiting further development, 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 were aware of this requirement but the format that this report would take had still to be finalised.

The experiences and views of residents were used to improve care practice and quality of life. There was a residents' advocacy group comprising of residents, their families and friends who met every three to four months.

Aspects of this action not completed to a satisfactory standard are restated in the action plan at the end of this report.

5. Action required from previous inspection:
Ensure the nominated person in the centre to deal with complaints is documented on the complaints procedure.

This action was partially completed.

Inspectors viewed a centre specific complaints policy in a folder with a copy of the Health Service Executive policy 'Your Service Your Say' which was easily accessible for reference if required. The local policy advises a process to follow if the complaint is not resolved locally on the unit. Timescales for completion and the option of independent appeal was also stated. The person in charge was the nominated complaints officer, this was displayed clearly but this information was not stated in the policy reviewed.

Aspects of this action not completed to a satisfactory standard are restated in the action plan at the end of this report.

6. Actions required from previous inspection:
Provide to the Chief Inspector of Social Services, together with the application for registration or renewal of registration, written confirmation from a competent person that all the requirements of the statutory fire authority have been complied with.

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

Ensure all fire equipment is in working order.

This action was partially completed.

An evacuation risk assessment was completed for each resident and maintained in an easily accessible place on each unit. The listing of each resident's evacuation need and the individual method of evacuation required was noted to be available in each Unit. Staff were trained in fire safety and according to the records had participated in a fire drill. The person in charge and provider told inspectors that an external area outside the emergency exit doors from Our Lady's Unit was risk assessed and work was scheduled to reduce the potential risks posed to residents by the rough and uneven surfaces, in the event of having to evacuate externally. Staff spoken with were knowledgeable regarding evacuation procedures and response in the event of fire.

An emergency plan was in place which dealth with the emergency from a global perspective with key action cards to prompt various levels of response at unit level.

Inspectors noted that equipment was routinely checked to ensure it was in working condition at all times in case it was required. Extinguishers and hose reels were serviced in September 2011. Records indicated that fire extinguishers were checked weekly. There was a fire safety register on each unit to maintain accurate records. The actions in take on discovering a fire were clearly displayed.

Confirmation from a competent person that all the requirements of the statutory fire authority have been complied with is pending and is expected within the next weeks.

Aspects of this action not completed to a satisfactory standard are restated in the action plan at the end of this report.

7. Actions required from previous inspection:
Ensure that the risk management policy covers the arrangements for the investigation and learning from serious or untoward incidents or adverse events involving residents.

Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

Put measures in place to prevent accidents to vulnerable residents in the centre by ensuring that open access to sluices, kitchenettes, the laundry and storage areas for cleaning chemicals is risk assessed.

Take all reasonable measure to prevent accidents to any person in the centre and in the ground of the centre.

This action was partially completed.

Although still partially completed, this action was at an advanced stage and was nearing satisfactory completion. A risk management policy was in place to inform staff on the procedures in regard to the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse

events involving residents. The policy also covered identification and assessment of risks throughout the centre, precautions in place to control risks identified including, residents absent without leave, assault, accidental injury, aggression and violence and resident self harm.

The person in charge informed inspectors that incident management and learning from serious or untoward incidents or adverse incidents involving residents in the Sacred Heart Hospital Castlebar was informed by the implementation of the HSE Incident Management Policy & Procedure 2008, the HSE Risk Escalation Procedure 2012. Communication of the learning from accidents/incidents reviews was done to units within the Sacred Heart Hospital via staff meetings.

Key pads were now fitted on all accessible doors to high risk areas since the last inspection in November 2011 such as kitchenettes, sluices and clinical rooms in each of the units.

Residents all have fall risk assessments completed and documented in the sample of resident files reviewed. Those who are assessed as being at risk of falling are proactively managed e.g. appropriate footwear in place, hip protectors in place, and Low-Low Beds, Chair and Bed Movement Sensor alarms in place, crash mattresses placed beside beds when required. The Physiotherapist and Occupational Therapists are involved in devising falls prevention programmes for residents. Procedures post fall includes referral of these esidents for assessment by the physiotherapist especially in the case of repeated falls.

The Sacred Heart Hospital has a site specific safety statement with associated risk assessments in place which identifies control measures to mitigate accidents within the centre and in the external areas. Inspectors noted that while these risks were identified, on-going risk of trip was in evidence due to very poor condition of floor covering on parts of the main circulation corridor in the centre. Light coverings and bulbs were also missing at numerous points throughout the corridor areas which were not documented in the risk register. The provider and person in charge told inspectors that they were working to resolve these issues.

Aspects of this action not completed to a satisfactory standard are restated in the action plan at the end of this report.

8. Action required from previous inspection:
Ensure each resident has a contract that deals with their care and welfare of the resident in the centre and includes details of the services to be provided for them and the fees to be charged.

This action was partially completed.

Not all residents had a signed contract of care in place. However progress on this action was delayed due to time required in finalising content and completion of printing. These copies of contract of care were nearing completion and delivery to

the centre. The provider and person in charge planned to distribute them for signing during April and complete collection of the signed contracts in May 2012.

Aspects of this action not completed to a satisfactory standard are restated in the action plan at the end of this report.

9. Action required from previous inspection:
Put procedures in place where all information relating to residents is included in a directory of residents meets the legislative requirements.

This action was satisfactorily completed.

A register was maintained at ward level recording all resident transfers which informed a daily update of the main directory of residents kept centrally in the Nursing Administration Office. All required information was recorded in this register. Short periods where residents are out of the centre were recorded on the register.

10. Action required from previous inspection:
Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.

This action was partially completed.

The new care plans require completion of - a Key to Me, Personal Calendar of Important Dates, Meaningful Activities Assessment which will lead to planned exploratory, sensory and reflex activity levels assessment. This assessment informs the creation of a meaningful activities programme for each individual resident. Inspectors viewed this documentation and found it to be very resident centred. For example, one resident identified she liked to read books but had noted that her vision was deteriorating. A referral to the optician was made who assessed her reading requirements and noted that she needed additional concentrated light which was provided in the form of an angle-poised lamp. Some residents had a separate reading table in addition to their bed table. Another resident with impaired vision was assed by the National Council for the Blind who provided large print books and CDs. There was greater focus in most areas on promoting personal choice by facilitating residents to select their own clothes. Inspectors noted that while recreational activities were of a good standard in St Anthony's Unit there was evidence of insufficient recreational therapies on St John's Unit. Seven residents were seated in the sitting room. None of these seven residents were interested in or were viewing the DVD playing on the large television screen in this room.

Aspects of this action not completed to a satisfactory standard are restated in the action plan at the end of this report.

11. Actions required from previous inspection:
On each occasion that restraint is used, record the nature of the restraint and its duration.

Provide a high standard of evidence based nursing practice in relation to restraint management.

This action was partially completed.

This action plan was not significantly advanced from findings of previous inspection in November 2011. Inspectors noted from the training records referenced that staff had commenced the 'Train the Trainer' programme on restraint management. However the policy had not been implemented in practice. Restraints were not identified as an area requiring care in the care plan documentation.

A steering group with representatives from each unit who had completed the training was been established with an inaugural meeting planned for the 18 April 2012. This group were being put in place to lead out on implementation of evidence based restraint procedures. The centre did not maintain a restraint register.

Review of residents' documentation in this areas confirmed that assessment of need was not completed in each case of restraint use. Use of the least restrictive means of restraint for the least amount of time was not explicitly referenced as trials of alternative options was not documented. The documentation does not reference who was involved on the multidisciplinary team deciding on restraint use when a resident is unable to make that decision themselves.

Bedrails were referenced as 'cot sides' in some places which is not evidence based. There was inconsistent monitoring of restraint application and release schedules both for bedrail and lap belt use.

Aspects of this action not completed to a satisfactory standard are restated in the action plan at the end of this report.

12. Action required from previous inspection:
Provide staff with training in facilitating recreational activities pertinent to their role.

This action was satisfactorily completed.

The approach to recreational activity provision was changed since the last inspection to enable all staff to take responsibility for this area of resident care. Twenty two staff attended a workshop on the 13 April and to be repeated on the 08 June 2012. The team were at the planning stage of introducing therapeutic programmes for residents with conditions affecting their ability to communicate. The aim of the training is to provide staff with the skills to be able to provide opportunities for each resident to participate in appropiate activities. A qualified reflexologist attends the centre and treats residents free of charge.

13. Action required from previous inspection:
Make arrangements for residents to have adequate storage facilities for their clothing.

This action was partially completed.

Inspectors found inconsistencies in provision of adequate storage facilities for residents' clothing across the three units. Residents in St Anthony's Unit enjoyed adequate storage facilities and space due to the reduced numbers of residents now accommodated there. Residents in St John's unit had adequate storage facilities mainly due to the additional space provided by recent refurbishment. The provider and person in charge told inspectors that they had supplied additional lockers and wardrobes which were seen by inspectors.

However, storage space remained inadequate on Our Lady's Unit. Residents did not have adequate space to store all their belongings alongside their beds in the multioccupancy rooms. Inspectors viewed residents' personal clothing and other items stored in wardrobes along the main corridor. Some of the wardrobe doors were ajar and did not have handles or locks on them to allow them to be closed or secured. One of these wardrobes viewed was shared by three residents who had a shelf each. One of the multioccupancy rooms was closed on the day of inspection for upgrading of insulation to the walls to improve the efficiency of the heating in this area.

Aspects of this action not completed to a satisfactory standard are restated in the action plan at the end of this report.

14. Action required from previous inspection:
Put in place a system to ensure that monitoring and documentation of nutritional intake is in sufficient detail to enable any person inspecting the record to determine whether the diet is satisfactory , and of any special diets prepared for individual residents as required under schedule 4 (12) of the regulations.

This action was satisfactorily completed.

A system was introduced since the last inspection in November 2011 to identify those at risk of poor nutrition. Staff were no longer relying on monthly weights or day to day feedback from each other to manage and evaluate residents nutritional wellbeing. An ongoing documented system of monitoring on a meal by meal basis was now in place for residents who were at risk of taking inadequate nutritional intake. Where residents do not take an adequate intake for more than two meals they are commenced on a three day food diary and referred to the dietician for review. Three day diaries were complete and provided rich information for the dietician to complete their assessment of intake. A multidisciplinary team consisting of the Person in Charge, dietician and catering manager developing a nutritional and food service audit to look at the quality of the food service from a number of angles.

Residents with poor dietary intake are prioritised for assessment by the Speech and Language Therapy service. Following review of residents, the Speech and Language Therapy service document their recommendations in the residents file and email the catering department with changes as required.

15. Actions required from previous inspection:
Provide a high standard of evidence-based nursing practice in relation to bowel management.

When a resident required specialist speech and swallow therapy and any other service as may be required access to such service is facilitated by the provider.

This action was satisfactorily completed

An audit was commenced on the 01 April on the use of aperients for residents in the centre, the aim being to endeavour to reduce the use of medicinal aperients where possible. A database of residents taking aperients was maintained and work was in progress since the inspection in November 2011 to increase natural aperients in residents' diets such as orange juice, prune juice and introducing increased fibre into some other residents' diets with the dietician and residents input.

A system for referral of residents who require Speech and Language Therapy service review is now established. All thirty three residents who were identified in previous reports by the Authority as requiring improved referral management were completed by the 23 February 2012.

16. Actions required from previous inspection:
Put systems in place to ensure that residents' needs are set out in an individual care plan developed and agreed with each resident.

Keep the resident's care plan under formal review in response to the residents changing needs and maintain a three monthly.

This action was partially completed.

New accredited care plan documentation in the form of integrated minimum data was being introduced gradually for each resident. Each staff nurse in the centre had responsibility for completing a number of care files. This documentation requires three monthly reviews and rewriting every six months. A comprehensive centre wide training plan was in progress. Staff were positive regarding the benefits of this new documentation for managing resident care.

The new documentation prompts responses with clear assessments, identification of needs, referrals if necessary and care plans to meet needs. The process will be audited at various stages of implementation to ensure it is on target and staff are provided with adequate training in using it.

The majority of care planning documentation used in the centre on the day of inspection was in the older format. Inspectors found that while there were deficits which the new documentation would address, there were other deficits that required consistency and diligent effort to ensure this documentation was adequately completed at all times to inform resident care.
For example residents' records recording the activities they engaged in were not consistently completed. A daily narrative note was not completed for all residents. Residents did not sign their agreement with the care plans developed to meet their needs.

Aspects of this action not completed to a satisfactory standard are restated in the action plan at the end of this report.

17. Actions required from previous inspection:
Set out each residents needs in an individual care plan developed and agreed with the resident, individual comprehensive multidisciplinary plans of care to be devised for all residents with wounds to ensure sufficient care to maintain each resident's welfare and wellbeing.

Provide staff with training in contemporary evidenced-based wound care management and pressure area care management.

This action was partially addressed.

A wound care steering group including the dietician was being set up to oversee wound care management and pressure area care management in the centre. Four nurses who were representatives from each of the units were completing a Tissue Viability training module. Revision of the wound care plan was pending the completion of the tissue viability training module. This training was supplemented by other staff attending one day refresher courses in this area.

On the day of inspection, there were no residents in the centre with pressure related skin ulcers. However there were residents with other wounds some of which presented challenges with healing and required complex dressing procedures. There was evidence of good referral and review by the vascular and plastic surgery teams in the acute services.

There was also a plan for review of wound care policies and procedures by the newly trained cohort of staff. This group also planned to review wound management plans and audit this area of practice.

Aspects of this action not completed to a satisfactory standard are restated in the action plan at the end of this report.

18. Actions required from previous inspection:
Provide a sufficient number of toilets and bathing facilities to meet the individual needs of the residents.

Put procedures in place where the walls of the lobby to the laundry, the floors in corridors and residents commodes are sufficiently maintained to ensure they are in a clean state at all times.

Revise on-going maintenance procedures in the centre to ensure all repairs are completed.

Review current and provide appropriate, safe and accessible storage facilities for all equipment used by residents.

Put monitoring systems and controls in place to ensure that hot water temperatures at the point of contact do not exceed 43 degrees centigrade.

Provide a call facility by residents' beds to allow residents summon assistance.

This action was partially completed.

There were systems in place for the repair and maintenance of equipment. Call bells were now in place in all areas. Residents told inspectors that they were familiar with the system and found them easy to use. Thermostatic valves were fitted to the hot water tap systems controlling water temperatures at the point of contact at a level not greater than 43 degrees centigrade

The inspector observed residents move freely around the building. The provider and staff had made a significant effort to promote the values of privacy and dignity by making adaptations to areas of multiple occupancy in St Anthony's unit 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 work in improving personal space in this area had resulted in a comfortable welcoming environment being created for residents. There was evidence of an ongoing programme of decoration in this unit. However this was not the case in Our Lady's unit which was cramped and cluttered with residents' equipment.

The physical environment did not comply fully with the specifications of the *National Quality standards for Residential Care Settings for Older People in Ireland.* To meet the needs of thirty five residents in Our Lady's Unit. While improvements had been made to the personal space available for residents the following factors impacted on privacy:

Layout and design
The layout and design of the multi occupancy rooms in the unit makes it difficult to provide for residents' individual and collective needs in a meaningful way that enabled the promotion of values such as privacy and dignity. Each room accommodates six residents and measures 70m² which divided gives the impression

that each resident has 11.66 m² per resident however due to the layout of the room the true space for each resident is inadequate to meet their needs. This personal space is further compromised by storage of wheelchairs, hoists and specialist chairs. Limited storage space for equipment also impacted on residents' communal space as it was used for storage of resident equipment. Corridors, bathroom/showers and toilet areas were also used extensively for storage. On the April 03 inspection, the inspector noted that the multioccupancy rooms were used for storage of wheelchairs and specialist chairs. The inspector also noted that three laundry trolleys and hoist slings were stored in a bathroom. Resident equipment was stored at various points along the main corridor of the unit impeding access to handrails which increased risk of fall to vulnerable residents and limited residents' independence.

A doorway between the shower-room and a storeroom had no door fitted on it, a screen was fitted over the door when the shower was in use and therefore did not address all aspects of residents' right to privacy and dignity while showering.

Residents did not have adequate or sufficient storage space for their personal clothing. Many residents' clothing was stored in cupboards along the main corridor of the unit, therefore residents clothing was not within access to them and residents. This practice also impacted on residents' privacy, dignity and choice. One wardrobe was shared by three residents as they had a shelf each. Some of these wardrobes on the unit's main corridor did not have handles or locks and some were ajar with residents' clothing visible.

Resident meal times were not a social occasion; there was insufficient space for all residents to dine together on Our Lady's Unit on the inspection of April 4th 2012, inspectors noted that the room was used as a dining/sitting room. There were ten residents in assistive chairs in the room who were being assisted by staff with eating. There was insufficient dining space for all residents to dine together in the dining/sitting room tables and residents were noted to be either dining by their bedsides or while in bed.

A multi-occupancy room at the end of the unit was closed and was undergoing refurbishment. Inspectors were told that a 'dry-lining' procedure was in place to improve insulation in the room as residents found it cold. Inspectors could not access the area as it was securely closed while work was in progress. Inspectors were also told that five residents were awaiting admission when the room was refurbished.

There is an inadequate number of toilets and showers to meet the needs of 35 residents in Our Lady's Unit (Short by I shower and 1 toilet)

Aspects of this action not completed to a satisfactory standard are restated in the action plan at the end of this report.

19. Actions required from previous inspection:
Put in place a comprehensive policy on all aspects of medication management to reflect An Bord Altranais' *Guidelines for Registered Nurses* and as outlined in Standard 14.3 of the *National Quality Standards for Residential Care Settings for Older People in Ireland 2009.*

Make arrangements for medical review of residents' medication on a three monthly basis.

Ensure nurses' signatures are entered on nursing administration records when medications are administered.

Conduct an audit in respect of medication review for the purposes of ensuring the quality and safety of care provided in relation to the ordering, prescribing and administration of medicines. Make a copy of this review available to residents and to the chief inspector.

This action was satisfactorily addressed

The Medication management policy was revised and was in place. Medication prescription and Administration documents were reformatted so that all medications must be re-prescribed every ninety days (three months).

The medical officer has worked and engaged with the team resulting with the outcome that residents' and their medications are reviewed on a three monthly basis.

An audit was carried out on medication management practices on the 19 March 2012. Findings included that omissions in nurses signing when medications were administered could be directly linked to disturbances which completing the medication round. In response, signage was displayed when medications were been administered to residents. Other alert tools were considered which included coloured aprons which are being sourced. Use of name bands has been replaced with placing the residents photograph on the medication documentation for cross reference by the dispensing nurse.

Medication auditing has already commenced in Our Lady's Unit and the Person in Charge was also carrying out an audit which examined ordering, prescribing and administration of medicines. A sample was taken from each Unit. As a result, all staff was offered accredited training to refresh and update practices.

20. Action required from previous inspection:
Provide adequate and appropriate communication aids to meet residents needs and to enable them to express their wishes.

This action was partially completed.

Progress has been made in this area since the last inspection. Four sets of Talking Mat tools had been purchased. Each set includes a dementia and aphasia pack. Explanatory DVDs were included. In addition one person will be trained on the 14 of June to further enhance the utilisation of this communication aid. However, at the time of inspection these tools were not utilised due to the need for training. Plans were in the preparatory stages for speech and language therapy services to provide

this training to staff in the centre to ensure optimum benefit and outcome for residents.

The new care plan documentation has a communication module which assesses speech, hearing, vision, cognitive, emotional and behaviour aspects of residents' communication capabilities. As this is not fully introduced, it is envisaged that it will assist nurses in assessing level of need and providing appropriate aids to enable residents to express their needs and wishes.

Aspects of this action not completed to a satisfactory standard are restated in the action plan at the end of this report.

21. Action required from previous inspection:
Provide each resident with a copy of the revised document.

This action was satisfactorily completed.

Clinical nurse managers took responsibility for distribution of the resident's guide locally on each unit. A copy of this document was given to the resident or their next of kin. Copies of the residents guide were viewed by inspectors and were located by the resident's bed in their bedside locker. Additional copies were available if required.

22. Actions required from previous inspection:
Ensure each resident receives a high standard of service from the medical officer with whom he/she is registered including regular and timely consultations that are responsive to each resident's needs.

Ensure appropriate and sufficient access to the medical care to meet the medical needs of residents.

This action was satisfactorily completed.

The provider had discussions with the Medical Officer and the on-call arrangements by the acute hospital services in relation to medical cover for the centre. Areas of deficit were addressed and were resolved.

Three monthly medical reviews were completed in February 2011 for all residents referenced by an entry in each resident's medical record. This process was due again in April 2012.

23. Action required from previous inspection:
Revise and implement polices and procedures to comply with current legislation, regulations and Standards.

This action was satisfactorily completed.

A suite of policies and procedures were in recently introduced for implementation. A copy of these policies and procedures were available on each unit. They were stored in alphabetical order and were readily accessible if required to inform or reference practice. The Clinical nurse managers led out on implementation of these documents at unit level with staff.

24. Action required from previous inspection:
Ensure all staff employed in the centre have the documents outlined in schedule 2 of the Health Act 2007 (Care and welfare of residents in Designated centres for Older people) Regulations 2009 (as amended) including three references and certificates of physical and mental fitness.

This action was partially completed

This action was well advanced since the inspection of November 2011. An audit of all documentation held was completed. The audit identified what documentation was still required in respect of each staff member. Foundation work had been completed in obtaining outstanding documentation. A letter had been forwarded to each employee highlighting what is missing on their file. Inspectors reviewed a total of nine staff files and noted that none were compliant with the legislative requirements.

Aspects of this action not completed to a satisfactory standard are restated in the action plan at the end of this report.

Report compiled by:

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

03 April 2012

Chronology of previous HIQA inspections	
Date of previous inspection:	**Type of inspection:**
29 September 2010	☐ Registration ☒ Scheduled ☐ Follow-up inspection ☐ Announced ☒ Unannounced
03, 04 and 05 May 2011	☒ Registration ☐ Scheduled ☐ Follow-up inspection ☒ Announced ☐ Unannounced
Ist Meeting - 14 October 2011	☐ Registration ☐ Scheduled ☐ Follow-up inspection ☒ Meeting ☒ Announced ☐ Unannounced
22 November 2011	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☐ Meeting ☐ Announced ☒ Unannounced
2nd Meeting - 08 February 2012	☐ Registration ☐ Scheduled ☐ Follow-up inspection ☒ Meeting ☒ Announced ☐ Unannounced
3rd Meeting - 29 February 2012	☐ Registration ☐ Scheduled ☐ Follow-up inspection ☒ Meeting ☒ Announced ☐ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

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

Provider's response to inspection report *

Centre:	Sacred Heart Hospital
Centre ID:	0648
Date of inspection:	03 April 2012
Date of response:	05 June 2012

Requirements

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

1.The person in charge has failed to comply with a regulatory requirement in the following respect: Did not ensure that the numbers of staff on duty were appropriate to meet the care welfare and safety needs of residents at all times as:	
Action required: Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.	
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:**

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

Provider's response: Currently using RCN tool for monitoring dependency levels, Nurse in charge reviews staffing levels in line with assessed dependencies of the residents on a daily basis. Changes in allocated staffing levels due to unplanned absences are addressed using additional hours. As the inspectors noted, six staff had been transferred from other departments within the hospital to direct patient care. This enhanced the staff/patient ratios in each of the three long stay wards. The need for further additional Staff will be considered in the context of the previous paragraph. Piloting Rhys Hearn Dependency Assessment tool on one unit to identify if tool will assist clinical nurse managers to adapt nursing hour prediction and utilise skill mix identification. The proposed reduction in the overall bed compliment from 90 to 77 will increase the staff/patient ratio and this will be kept under review.	completed 01 July 2012

2. The provider has failed to comply with a regulatory requirement in the following respect: A copy of the reports in respect of reviews conducted for the purposes of Regulation 35(1) was not made available to residents.	
Action required: Make a report in respect of any review conducted by the registered provider for the purposes of Regulation 35(1), and make a copy of the report available to residents and, if requested, to the Chief Inspector.	
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 following the inspection with timescales:	**Timescale:**
Provider's response: Copies of the reports under Regulation 35(1) will be made available to residents.	 June 2012

3. The provider has failed to comply with a regulatory requirement in the following respect: Did not ensure that the complaints procedure contained details of the nominated person in the centre to deal with complaints as required by the legislation.	
Action required: Provide written operational policies and procedures relating to the making, handling and investigation of complaints from any person about any aspects of service, care and treatment provided in, or on behalf of a designated centre.	
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: Copy of signage re complaint's policy was forwarded to the Health Information and Quality Authority (the Authority) on 28 March 2012. It is again confirmed that the name of the Director of Nursing is included on all of the complaint's policy notices that are distributed throughout the hospital.	May 2012

4. The provider has failed to comply with a regulatory requirement in the following respect: Did not provide to the Chief Inspector of Social Services, together with the application for registration, written confirmation from a competent person that all the requirements of the statutory fire authority have been complied with.	
Action required: Provide to the Chief Inspector of Social Services, together with the application for registration or renewal of registration, written confirmation from a competent person that all the 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: Our estate's department have confirmed that written confirmation regarding fire compliance from a competent person will be available by mid June 2012.	Mid June 2012

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

Risk assessments had not identified all the hazards in the centre.

Floor covering was not safe in all areas.

The external areas to the back of the centre were still not of a safe standard.

Action required:
Provide safe floor covering.

Action required:
Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

Action required:
Take all reasonable measure to prevent accidents to any person in the centre and in the ground of the centre.

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

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
An architect has been appointed to review and assess all risks in the Hospital. The initial evaluation visit has been scheduled for 31 May 2012.	31 March 2012
Replacement of floor covering, where required, is being arranged with our estates department.	June/July 2012
The hospital grounds, particularly at the rear, are being re-instated to ensure safety of patients and also to facilitate safe evacuation of patients in the event of fire.	June 2012

6. The provider has failed to comply with a regulatory requirement in the following respect:
All residents did not have agreed contracts for the provision of services.

Action required: Ensure each resident has a contract that deals with their care and welfare of the resident in the centre and includes details of the services to be provided for them and the fees to be charged.	
Reference: Health Act, 2007 Regulation 28: Contract for the Provision of Services Standard 7: Contract/Statement of Terms and Conditions	
Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response: The new nationally agreed contract's of care for Fair Deal and pre Fair Deal patients are currently being completed	June 2012

7. The person in charge has failed to comply with a regulatory requirement in the following respect: There was inadequate provision of meaningful, appropriate activities for residents in St Johns Unit. The inspector observed residents sitting for long periods of time in the day/sitting room with no social interaction.	
Action required: Provide opportunities for each resident to participate in activities appropriate to his /her interests and capacities.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Regulation 10: Residents' Rights, Dignity and Consultation Standard 18: Routines and Expectations	
Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response: Staff have been for training on a Sonas programme and the equipment needed to carry out meaningful activities with residents with dementia is being actioned by the units. The new care plans are being implemented as they are completed and the a key to me section is highlighting activities for the residents. A new form is being introduced that records the activities the residents have taken place in on a daily basis. This action will be audited and progressed as an ongoing piece of work. St. John's has an art therapist visiting the unit	30 June 2012

on a Friday morning, a new project has been commenced on St. John's utilising the outside garden to engage residents in outdoor activities with the development of the garden. Residents are also attending the day centre. There are two part-time activities personnel employed for the long Stay Units and their roles are being reviewed to ensure provision of relevant services. The newly appointed clinical support manager will assist in ensuring the completion of this action.	June 2012

8. The provider has failed to comply with a regulatory requirement in the following respect: Adequate records were not maintained for every occasion where restraint was used, the nature of the restraint and its duration. All aspects of restraint management were not based on evidenced-based nursing practice	
Action required: Maintain, in a safe and accessible place, a record of any occasion on which restraint is used, the nature of the restraint and its duration, in respect of each resident.	
Action required: Provide a high standard of evidence-based nursing practice in relation to restraint management.	
Reference: Health Act 2007 Regulation 6: General Welfare and Protection Regulation 25: Medical Records Standard 18: Routines and Expectations Standard 21: Responding to Behaviour that is Challenging	
Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response: The national restraint policy is currently in place and documentation has been introduced to the units specifically a restraint register a restraint release and review chart and a brief risk balance tool. Information sessions for all staff are	30 June 2012

being provided on the restraint policy and a review of all restraints will take place. A steering group has been put in place to progress the area of restraints from a strategic level and they will review and audit the practice on each unit to ensure progression and evidenced based best practice. The newly appointed clinical support manager will assist in ensuring the completion of this action.	 Ongoing review

9. The provider and person in charge has failed to comply with a regulatory requirement in the following respect: Did not ensure there was suitable provision for storage of residents clothing in the centre. Residents were not provided with suitable secure storage whereby they could retain control over their personal property and valuables.	
Action required: Provide adequate space for a reasonable number of each resident's personal possessions and ensure that residents retain control over their personal possessions.	
Action required: Provide adequate facilities for each resident to appropriately store, maintain and use his/her own clothes.	
Reference: Health Act, 2007 Regulation 7: Residents' Personal Property and Possessions. Regulation 13: Clothing Standard 17: Autonomy and Independence Standard 25: Physical Environment.	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Architect appointed to review all spatial issues to ensure compliance with the Regulations. This will include storage facilities for patients' personal possessions and clothing. It is accepted that the overall bed numbers in the long stay units will be reduced from 90 to 77 in order to ensure that adequate space is available for each patient.	 June 2012

10. The person in charge has failed to comply with a regulatory requirement in the following respect:
There were deficits in the care planning process for residents in the centre:

- Did not consistently reflect the resident's current health status
- there was no evidence of resident involvement in developing his/her care plan or in a review of their care plan

Action required:
Put systems in place to ensure that residents' needs are set out in an individual care plan developed and agreed with each resident.

Action required:
Complete, and maintain in a safe and accessible place, an adequate nursing record of each resident's health and condition and treatment given, on a daily basis, signed and dated by the nurse on duty in accordance with any relevant professional guidelines.

Reference:
Health Act, 2007
Regulation 8: Assessment and Care Plan
Regulation 25: Medical Records
Standard 13: Healthcare
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: The new integrated minimum data documentation is being implemented for each resident, care plans will be agreed with the residents and their families and co-signed to promote partnerships in care. Within the documentation there is a daily flow chart to aid consistency, and will be completed daily. The process will be audited and the results disseminated to the nurses who have completed the documentation. Training is being provided for all staff. The residents care plans will be updated and reviewed on a three monthly basis and rewritten every six months, unless there was a change in the resident's condition which would be reflected in the documentation on the day. The newly appointed clinical support manager will assist in the completion of this action.	30 June 2012 Ongoing review

11. The provider has failed to comply with a regulatory requirement in the following respect:
Care of residents with wounds did not have access to contemporary evidence-based wound care management.

Action required:
Provide a high standard of evidence based nursing practice in relation to wound care.

Reference:
Health Act, 2007
Regulation 6: General Welfare and Protection
Standard 13: Health Care
Standard 18: Routines and Expectations

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The National Wound Care Guidelines are being utilised to promote best practice on the units. The steering group will look strategically at the progression of best practice on an ongoing basis utilising the national guidelines. New documentation to chart the wounds are being developed and each unit has access to a wound measurement tool and depth indicators have been ordered. Cameras are also available to photograph the wound with the consent of the resident which is contained in the new DML records. A new chart which shows the different progress of wounds for example sloughy/granulating has been sourced and the correct dressing for use as a primary/secondary eg hydrocolloid/alginate are shown. The eupap grading is also to be utilised. Audit tools will be developed to measure the process. It is also planned to audit current dressing use. Local wound care guidelines will be progressed. The MUST tool is being completed are prescribed. Regular updating in wound care to be progressed with all staff.	30 June 2012 on-going

12. The provider has failed to comply with a regulatory requirement in the following respect:
The residents' personal and communal space was not designed and laid out in a manner to ensure their safety, encourage and aid their independence and assure their comfort and privacy.

Action required
Provide a sufficient number of toilets and bathing/showering facilities to meet the individual needs of the residents in Our Lady's Unit.

Action required
Ensure the premises are kept in a good state of repair externally and internally.

Action required
Review current and provide appropriate, safe and accessible storage facilities for all equipment used by residents.

Action required
Provide adequate dining space separate to the residents' private accommodation.

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 review by the architect will include the adequacy of toilet/showers for patients in all wards and in particular Our lady's Ward, in order to comply with the National Quality Standards. All of these issues will also form part of the architect's brief. The reduction in the bed numbers in this ward will ensure adequate space being available for each patient, including space for storage of personal items and clothing.	June 2012

13. The provider has failed to comply with a regulatory requirement in the following respect:
Did not put practices in place that facilitated and encouraged each resident to communicate due to a lack of staff training on use of talking mats.

Action required:
Provide staff members with access to education and training in use of communication tools to enable them to utilise these communication tools in accordance with contemporary evidence-based practice.

Reference:
Health Act, 2007
Regulation 11: Communication
Regulation 17: Training and Staff Development
Standard 17: Autonomy and Independence

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Assessments using DML on communication will be completed for all residents and will highlight communication deficits. Sonas training will enable staff to provide opportunities on a individual level to residents to participate in appropriate activities. Talking mats have been purchased and are on each unit. Training for talking mat on 14 June 2012. Train the trainers programme.	June 2012

14. The provider has failed to comply with a regulatory requirement in the following respect: Personnel files did not contain documents detailed in schedule 2 of the Health Act 2007 (Care and welfare of Residents in Designated Centres for Older people) Regulations 2009 (as amended). Evidence of An Garda Siochana vetting and certification of physical and mental fitness to work were not included in all files reviewed.	
Action required: Ensure all staff employed in the centre have the documents outlined in schedule 2 of the Health Act 2007 (Care and welfare of residents in Designated centres for Older people) Regulations 2009 (as amended) including three references and certificates of physical and mental fitness.	
Reference: Health Act, 2007 Regulation 24: Staffing Records Standard 22: Recruitment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All personnel files for staff in the hospital have been reviewed as witnessed by the inspectors during their visit on 3rd April 2012. Outstanding information in relation to references, Garda Síochána vetting etc, continue to be followed up, until completion.	JUNE 2012 and ongoing.

Any comments the provider may wish to make:

Provider's response:

None supplied

Provider's name: Michael Fahey
Date: 05 June 2012