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Sacred Heart Residence, Little Sisters of the Poor, Sybil Hill Road, Raheny, Dublin 5.

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**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:	lspoffraheny@eircom.net
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):	Sheila McKeivitt
Type of inspection	Unannounced
Number of residents on the date of inspection:	84
Number of vacancies on the date of inspection:	2

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: 12 November 2015 09:25 To: 12 November 2015 21:05

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 04: Suitable Person in Charge	Compliant
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 - Major
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Non Compliant - Major
Outcome 11: Health and Social Care Needs	Non Compliant - Major
Outcome 18: Suitable Staffing	Non Compliant - Major

Summary of findings from this inspection

This was an unannounced inspection of the centre for the purpose of monitoring compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. There were 84 residents residing in the centre at the time of inspection.

During the inspection practices were observed, and relevant documentation reviewed including care plans, medical records, accident and incident logs, policies and procedures, and staff files. Inspectors also talked to residents and staff. The inspectors also met with the person in charge and the operations manager for the centre.

Evidence of good practice was found throughout the inspection, and staff were knowledgeable of the residents, and were observed to treat all residents with dignity and respect throughout the inspection. The person in charge, the operations manager and the assistant director of nursing were committed to providing a good standard of care to the residents, but the governance and management systems in place within the centre were not sufficiently robust to ensure a high standard of

nursing care was being delivered at all times. The system of auditing was not sufficiently comprehensive, evidence based or structured to detect deficiencies in the care being delivered. The system of staff supervision, and the management of the individual units in the centre required improvement. The annual review of the quality and safety of care delivered to residents had not been completed. The outcome on governance and management was found to be in major non-compliance with the regulations.

The person in charge was suitably qualified, demonstrated good knowledge of the residents and was well known to the residents. The outcome on suitable person in charge was compliant with the regulations.

The outcome on documentation was not examined in full during the inspection, but the inspectors identified a moderate level of non-compliance due to the inaccessibility of medical notes, and the standard of nursing documentation relating to wound care and other daily records maintained in the centre.

The outcome on safeguarding and safety was found to be in major non-compliance with the regulations. The use of bed rails in the centre required review as the procedures and processes in place were not in line with the national policy on restraint. The assessment and care planning process for managing challenging behaviour also required review to ensure appropriate management.

Outcome 8, on health and safety and risk management was deemed to be moderately non-compliant. The management of risk in the centre required review, as did the process for conducting fire drills.

Medication management practices in the centre also required improvement and this outcome was found to be moderately non-compliant overall. The cardexes (prescription sheets) and practices relating to the completion of the prescription sheets were not in line with best practice. The administration of PRN (as required) medicines did not always occur at recommended time intervals.

The system in place to ensure the person in charge was aware of all notifiable incidents was not adequate, and as a result pressure sores were not appropriately notified to the Authority. This outcome was deemed to be a major non compliance with the regulations.

Residents' healthcare needs were being met and residents had timely access to medical and allied health care team members. Nursing care was being provided to meet residents needs however, the nursing care being provided was not consistently evidence based nursing care. The assessment process was not always sufficiently comprehensive to accurately identify each resident's needs. The care plans in place did not consistently provide adequate information to guide care, and care plans were not in place for all residents' assessed needs. Poor care practices included manual handling, incontinence care and documentation relating to pressure sore management. The outcome on health and social care needs was in major non compliance with the Regulations.

A major non-compliance was also identified in the outcome on suitable staffing. The skills mix of staff was not appropriate to ensure the needs of the residents were met. There was no system in place to ensure that staff levels and skill-mix was linked to the residents' dependencies, assessed needs and the size and layout of the centre. The system of staff supervision was not adequate to ensure evidence based care was being delivered at all times. Communication systems were not adequate to ensure effective communication between all staff in the centre.

The action plan at the end of this report identifies those areas where improvements were required in order to comply with the regulations.

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):

No actions were required from the previous inspection.

Findings:

The governance structure was not sufficiently robust to manage the 86 bedded centre. The management team currently in place did not collectively have the required experience, qualifications, management and leadership skills to manage the centre effectively. The team consisted of the Person in Charge, an Operations Manager and an Assistant Director of Nursing (ADON). There were no clinical nurse managers employed in the centre.

The religious congregation had applied to the Authority requesting that the person in charge also be nominated as the provider nominee for the centre. However, during the course of this inspection inspectors discussed the appointment of the operations manager as the provider nominee, as this better reflected the system of management in place and would ensure the person in charge was supported and able to focus on the delivery of clinical care within the centre.

The standard of clinical audit was not robust enough to ensure a high standard of nursing care was being delivered at all times. Evidence-based auditing tools were not being used and audits were not being carried out on a regular, consistent basis to monitor if recommendations were implemented and improvements sustained. The ADON informed inspectors that audits were conducted on areas of practice such as use of restraint, medication management and nursing documentation. Inspectors saw the last comprehensive restraint audit was carried out in October 2015 and although it clearly identified the number of residents using restraint it did not make any recommendations on how or what measures were being taken to reduce the use of restraint, such as bed rails in the centre. There was no audit tool being used to assess residents' nursing documents and the findings of these audits were not recorded they were fed back directly to the staff nurse responsible for completing the documentation. Hence, all staff were not benefiting from learning as a result of the audit and practices were not

improving. The ADON had not attended training in relation to auditing in over three years.

The system of supervision in place within the centre required improvement. The nurse on duty on each floor was accountable for the floor while on duty but there was no identifiable nurse responsible for the overall management on each floor or on each unit to ensure effective supervision of the care being delivered on an on-going basis, and to ensure effective management of the floor or unit. There was one nurse on duty on each of the three floors. but as outlined in outcome 18, nurses' time was taken up with tasks such as administering medications, completing wound dressings and organising referrals. Staff meetings were not held on a consistent or regular basis to ensure effective communication between management and staff. Review of records of staff meetings indicated that a meeting for nurses had last taken place in October 2015, while on some units staff meetings had not taken place since September 2014.

Inspectors formed the view that the management systems in place were ineffective in that the auditing system, and the system of staff supervision and communication in place did not detect the deficiencies in the care being delivered as outlined in this report.

Inspectors were informed that an annual review of the quality and safety of care delivered to residents in the designated centre had not been completed to date. This annual review is required 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. From the evidence outlined throughout this report there is an urgent need to have such a review completed.

Judgment:

Non Compliant - Major

Outcome 04: Suitable Person in Charge

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The person in charge had not changed since the time of the last inspection. Inspectors had determined the fitness and suitability of the person in charge further to the appointment. The person in charge is a registered nurse and has demonstrated knowledge of residents and in turn is well known to residents and relatives living at the centre. As discussed under outcome two the person in charge is supported by an

operations manager and an assistant director of nursing.

Judgment:

Compliant

***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):

No actions were required from the previous inspection.

Findings:

This outcome was not examined in full during the inspection. Records are kept secure in the centre however, they are not all easily retrievable.

Residents' nursing and medical records were available for review. However, the medical records were not accessible to staff or residents on the floors as they were stored in the medical assessment office on the ground floor, when residents occupied the 1st, 2nd and 3rd floors. This meant that staff on the floor could not easily refer to them which in turn lead to recommendations made by visiting General Practitioners not being inputted/updated in the residents' care plan as discussed under outcome 11.

Medical and nursing records were not filed in chronological order. This meant that information could not be retrieved promptly. For example, out of date information (more than seven years old) was filed with current relevant information. Hence, it took a considerable amount of time for one to get a clear picture of the residents' status. Given the large size of the centre this required improvement.

The daily records completed by nursing staff did not outline the full range of care and treatment provided to residents. The records were not directly linked to the residents' care plans. Documents such as fluid balance record sheets were not being accurately completed by staff nurses at the end of a 24 hour period. In addition, records such as turning record sheets did not reflect that the care prescribed in the residents care plan, was being provided by care staff.

Inspectors found wound care records were incomplete. Wound assessment forms and wound care plans reviewed on this inspection for two 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.

The policy on the protection of vulnerable adults and procedures on abuse were not sufficiently detailed as outlined under outcome 7 and required review and updating to reflect national policy and procedures as outlined in 'safeguarding vulnerable persons at risk of abuse'.

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:

Residents spoken to felt safe and secure in the centre. The reception desk at the front door was manned and there was a visitors sign in book in place.

Inspectors found that some measures were in place to protect residents from being harmed or abused. Most of the staff had received training on identifying and responding to allegations of elder abuse. A centre-specific policy was available which gave guidance to staff on the assessment, reporting and investigation of any allegation of abuse. However, this policy was not sufficiently detailed and required review and updating to reflect national policy and procedures as outlined in 'Safeguarding Vulnerable Persons at Risk of Abuse' (HSE 2014). The person in charge and staff spoken to displayed knowledge of the different forms of elder abuse and were clear on reporting procedures. One notification relating to adult safeguarding had been notified to the Authority. The investigation report relating to the investigation was reviewed on this inspection, and the allegation was not upheld. It was not clear how this conclusion had been reached, which raised concern regarding the overall procedures in place for the investigation of such allegations.

There was a policy on, and procedures for, managing behaviours that challenge and a separate policy on the use of restraint. It required review as did restraint practices. The policy and practices in relation to the use of restraint were not in line with the national policy on restraint. Inspectors found that all residents that were at risk of falling were

consented by their general practitioner to have two bed rails put in place. The rationale on the residents' assessment for use of these bed rails was that the resident was at risk of falling. There was no evidence that other alternatives had been tried. The assessments for bed rails were not consistently completed by staff to reflect an adequate assessment of the risks and benefits associated with their use. The person in charge told inspectors that they did have limited access to alternatives to try, explaining that they had one low low bed and three crash mats for the whole centre. The inspectors reviewed the restraint register which showed that 29 of the 84 residents had bed rails in use. Inspectors observed that bed rails were not being applied to residents' beds in line with best practice. For example, one resident who had bed rails in place on both sides of her bed had a large gap between the end of bed and the end of the bed rail on either side. This left the resident at risk of entrapment.

The management of behaviours that challenge also required review. An assessment of one resident's behaviours had been completed, but there was no evidence that this assessment had been used to provide a care plan with sufficient detail to enable all staff to respond to such behaviour in a consistent, appropriate manner. The care plan in place contained insufficient guidance to staff on how to manage such behaviours.

All visitors were noted to have been greeted and signed in to a visitors' book at reception. The inspector observed the majority of staff delivering care in a way which safeguarded residents' dignity and also respected the individual rights of residents.

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):

No actions were required from the previous inspection.

Findings:

There was a health and safety statement in place within the centre. The management of risk in the centre required review, as did the process for conducting fire drills.

The risk management policy made available to the inspectors on the day of the inspection did not include the measures and actions in place to control the risk of abuse as required by the regulations. There was no evidence that there was an ongoing process in place within the centre to identify hazards and assess risks. There was no local risk register available for the centre.

Records were available in the centre confirming regular servicing of the fire alarm

system, emergency lighting, and fire extinguishers. A departmental fire audit was completed on a three monthly basis in the centre. The centre had an emergency plan in place detailing the action to be taken in the event of fire, gas emission, burst pipes and explosions. The fire evacuation procedure was on display throughout the centre. Records were available indicating that a number of staff had completed fire awareness training/fire drill training throughout the year, although one member of staff reported that no fire training had been provided since they had commenced working in the centre. One other member of staff was not clear as to the evacuation procedure in the centre. Other members of staff spoken to by the inspector were clear of the phased horizontal evacuation plan. Inspectors reviewed a number of staff files and it was not always clear if staff had received recent fire training as outlined in Outcome 18. Records of the fire drill training available in the centre were not sufficiently detailed to indicate exactly what the fire drill process involved, or to indicate if any learning had been identified during these drills. There were no records to indicate if a fire drill simulating night-time conditions had been conducted in the centre, or if staff had conducted a simulated evacuation of a non ambulant resident using assistive equipment. There was limited availability of assistive equipment to assist in the evacuation of residents.

Health and safety meetings were held in the centre, and records indicated that infection control issues were discussed at these meetings. A number of staff had received training in infection prevention and control, although it was not clear from the staff files examined by inspectors that all staff had received this training as outlined under Outcome 18.

Judgment:

Non Compliant - Major

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):

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

Findings:

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. However inspectors noted that for one resident a PRN (as required) medicine had not been administered at the recommended time intervals at all times. The prescription sheets and practices relating to the completion of the prescription sheets required review.

Medicines were stored securely in the centre in locked cupboards and on locked medication trolleys. There was a fridge available to store medicines that required refrigeration and the temperature of this fridge was checked and documented on a daily

basis. All controlled drugs were securely stored in one location within the centre, and the balances were checked daily. Out of date medicines were segregated and returned to the retail pharmacy business for appropriate disposal.

The inspector noted that dates of opening were not consistently indicated on prescribed eye drops and liquids to indicate the subsequent expiry dates. The inspector noted that the administration records for one resident's PRN pain relief medicine indicated that the medicine had been administered twice within a three hour time interval on two occasions in November, which was outside the recommended minimum dosing interval of four hours for this particular medicine.

The inspector reviewed a number of cardexes (prescription sheets) and administration records and noted a number of issues that did not comply with best practice. These included:

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

- a number of prescription sheets (cardexes) were not easy to read or interpret.

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

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

- crushing was not indicated for each individual medicine on the prescription sheet (cardex).

- each medicine on the prescription sheet (cardex) was not being signed for individually by the prescriber.

The pharmacist was facilitated to meet all necessary professional obligations to residents and visited the centre on a regular basis. A log was maintained of all visits to the centre by the retail pharmacy business supplying medicines to the centre. A pharmacist conducted medication management audits in the centre on a regular basis, and the assistant director of nursing conducted spot check audits on medication, although there was no evidence of any action plans arising from these audits to ensure appropriate learning from any issues identified. Spot checks were conducted on medication practices within the centre but as outlined in Outcome 2 a more comprehensive structured audit system of medication management was required within the centre that included evaluation and analysis of all aspects of the medication management cycle including administration practices. The person in charge and the assistant director of nursing reported that no medication errors had occurred in the centre. There was no system in place to record 'near misses' for medication-related incidents, and the inspectors discussed the importance of promoting an open culture regarding the reporting of medication related incidents including medication errors to ensure all such incidents could be investigated, learning could occur and any necessary changes to practice implemented to prevent reoccurrence.

Judgment:

Non Compliant - Moderate

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):

No actions were required from the previous inspection.

Findings:

The Authority was not informed of all required notifiable events within three working days.

This was partially due to poor communication between staff on each floor and the person in charge. This is discussed further under outcome 18. Inspectors were informed of two residents who had developed grade two pressure ulcers in the centre. Staff on the floors had not informed the person in charge of either of these pressure ulcers. Therefore, the Authority had not been informed within three working days as required by the Regulations.

Judgment:

Non Compliant - Major

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):

No actions were required from the previous inspection.

Findings:

Inspectors focused on health and nursing care issues. The social care needs of residents were not monitored during this inspection. Residents' healthcare needs were being met and residents had timely access to medical and allied healthcare team members. Nursing care was being provided to meet residents' needs however, the nursing care being provided was not evidence-based nursing care.

Nursing assessments and care plans were incomplete and those reviewed did not reflect

the actual status of the resident. Comprehensive assessments were completed for each resident on admission and reviewed on a three monthly basis by staff nurses. A sample of residents' assessments reviewed did not reflect the actual status of the resident. For example, one resident whose comprehensive assessment was reviewed in mid-September contained conflicting information. It stated that the resident was at high risk of falling, however the inspector saw, and staff confirmed, that the resident could not move independently any longer and was now confined to bed 6/7 days per week. His/Her status had changed over the past three months. He/She was transferred from her bed to the chair only on Sundays, when his/her family visited. From reviewing four residents' three monthly reassessments inspectors found sufficient evidence to state that residents were not being fully reassessed by staff nurses every three months, although they were completing the reassessment document.

Residents had care plans in place to reflect some of their care needs, however, the information within a number of care plans reviewed did not reflect the care being provided. This was confirmed by staff spoken with during the inspection. For example, the inspector read that one resident was assisted by two staff using a hoist to have a full bed bath each week. Staff informed inspectors that the resident was hoisted out of bed and had a bath in the assisted bathroom every Monday. However, there was no written evidence that this care was being provided. Staff informed inspectors that this information was not always written in the resident's care plan or daily evaluation but was in the shower/bath book kept at the nurses' station. Inspectors viewed this book which contained the name of each resident and their preferred bath/shower day, a clear indication of task orientated care rather than person-centred practice.

Inspectors saw that the care provided was not always of a high standard and was not always evidence based. For example, inspectors saw and care staff confirmed, that they placed two incontinent pads on one resident who was assessed as being doubly incontinent. They informed the inspector that the second smaller pad was put in place to protect the larger pad beneath from getting soiled.

Inspectors were informed by staff about two residents who had developed grade 2 pressure ulcers. The person in charge told inspectors she had not been made aware of these two pressure ulcers and therefore they had not been reported to the Authority. This is discussed further under Outcome 5 and Outcome 10. There was no care plan in place for one resident who had developed a pressure sore, and there was no appropriate documentation in place to ensure the progress of this wound could be adequately monitored. Residents who had been assessed of being at risk of developing pressure sores did not consistently have care plans in place for skin integrity, or any documentation relating to repositioning such as repositioning charts. Wound assessments for leg ulcers did not provide information to determine if the wound was healing or not.

Inspectors saw where care was not being provided as outlined in the residents' care plans. For example, one resident's care plan stated the resident required two-hourly turning while in bed, however, her turning record chart showed that the resident was only being turned every four hours at night. Another resident's care plan stated the resident required a fluid intake of 1.5 litres, however, the resident's fluid balance chart was not being accurately completed to reflect the volume of fluids being taken and was

not been totaled every day hence, one could not determine the volume of fluids the residents was consuming in a 24 hour period. This is actioned under outcome 5.

Nutritional care plans for residents assessed as being at risk of malnutrition were not sufficiently detailed. Two residents who had been assessed by a dietician had not had their care plans amended to reflect the advice given. The nutritional care plans in place only contained details regarding the resident's weight and nutritional assessments. The care plans lacked sufficient detail to guide staff to deliver consistent care.

Manual handling practices observed were not always to a high standard although all staff had attended manual handling refresher training since the last inspection.

Inspectors observed staff using a number of hoists, including sit to stand and full hoists to transfer residents from one place to another, such as from chair to chair, bed to chair or vice versa. Practice observed was good with staff communicating well with residents before and after the transfer. However, inspectors found that when residents required turning in bed two staff did this manually. Inspectors observed two carers turning a resident in bed and saw that appropriate assistive equipment was not used. Staff told inspectors they did have a set of sliding sheets but they could not be found on any of the three floors on the day of inspection. The person in charge told inspectors that there were three sets of sliding sheets in the centre, one set on each of the three floors. This number of sliding sheets was not adequate to meet the needs of residents who required assistance with a change of position. This lack of equipment was acknowledged on the day of inspection by the management team.

Judgment:

Non Compliant - Major

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) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

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

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

Findings:

The staffing levels were adequate, however, the skill-mix was not adequate to provide a high standard of nursing care to residents.

Residents spoken to by the inspectors were complimentary of the staff who worked in the centre. Residents lived on three floors. There were 25 residents on the first floor, 32 on the second floor and 27 on the third floor. There was just one staff nurse on each floor over a 24 hour period. Information about the dependency level of each resident provided to the inspectors was not accurate. It did not reflect the actual dependency level of residents that inspectors met. For example, inspectors met one resident identified at low dependency, however, staff all agreed the resident in question was high dependency. Therefore, it was difficult to determine the staff ratios required. The carers provided all the direct care to residents and were being supervised by sisters from the congregation. These sisters were volunteers who did not have their roles and responsibilities clearly outlined. The majority of the sisters had completed FETAC qualifications. There were usually two sisters appointed to each floor to supervise the carers on duty. One of the sisters present on the day of the inspection was new to the centre and had no formal qualifications in care of the elderly. However, the information gathered by inspectors during the course of this inspection provided clear evidence that the skill-mix of staff on duty had lead to poor standards of care being delivered to some residents.

The nurses' time was taken up with tasks such as administering medications, completing wound dressing, organising referrals to the allied health care team members, general practitioners and pharmacist. Hence, the care being provided was not being supervised by a qualified staff nurse on a consistent basis. The poor standards of care being delivered to some residents was not due to lack of training as all care and nursing staff had completed a lot of training in various care practices since the last inspection. It was clearly down to the quality of supervision in that non-evidence based care being delivered was not being detected.

The sisters who were supervising carers informed inspectors that they had garda vetting in place, however, one sister who was new to the centre had not completed mandatory training in the protection of residents against elder abuse.

A sample of staff files reviewed were in compliance with schedule 2. The staff confirmed, and inspectors saw evidence that staff had annual staff appraisals completed by the person in charge and the assistant director of nursing.

The work patterns and communication between staff on each floor required 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. The manner in which staff handover and team meetings were organised reflected this segregation of staff. Inspectors were informed that the person in charge, and the assistant director of nursing usually met with the sisters supervising the carers and staff nurses every six weeks and staff nurses on each floor met with the carers on each floor every month. However, the minutes did not reflect that the meetings were happening this frequently.

Staff rosters did not clearly identify the hours being worked by each staff member. The roster did not include the names of the sisters from the congregation who were volunteering on each floor. In addition, staff on each floor did not have access to the

manager's roster so they were always aware whether the PIC or ADON was on duty. This is actioned under outcome 5.

Training records indicated that training had been provided on a number of topics throughout the year including elder abuse, dementia training, challenging behaviour, patient moving and handling, fire safety, medication management, and infection prevention and control. However, from reviewing these training records it was not clear that all staff had received the necessary mandatory training including fire safety training, as there was no system in place (such as a training matrix system) to ensure that all staff had attended training and refresher training events.

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:

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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:	12/11/2015
Date of response:	14/02/2016

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 management team had not established an auditing system to ensure that the service provided was safe, appropriate, consistent and effectively monitored.

1. 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

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

monitored.

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

The Adon will put in place a monthly Key Performance indicator, which will reflect our audit. Matrix for Audit. We are advertising for A CNM Registered Nurse. We are also advertising for a part-time medical secretary

Proposed Timescale: 31/01/2016

Theme:

Governance, Leadership and Management

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

An annual review of the quality and safety of care delivered to residents in the designated centre had not been completed to date.

2. 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:

We have now begun to complete an annual review. Guidance from nursing Home Ireland.

Proposed Timescale: 29/03/2016

Theme:

Governance, Leadership and Management

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

The system of supervision in place within the centre was not sufficient as there was no individual nurse accountable on each floor or on each unit to ensure effective supervision of the care being delivered on an on-going basis, and to ensure effective management of the floor or unit.

3. 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:

One Nurse is allocated to each floor over a 24 hour period. The CNM we are currently recruiting will work opposite the ADON to ensure managerial Supervision cover over

seven days a week. This will ensure more effective supervision of patient care delivery on a daily basis through the registered nurse and the unit sister supervisor. The CNM will be responsible for monitoring the carers and inducting new staff.
Proposed Timescale: We are currently advertising for CNM

Proposed Timescale:

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 as outlined under Outcome 7 and required review and updating to reflect national policy and procedures as outlined in 'safeguarding vulnerable persons at risk of abuse'.

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:

The Abuse Policy has been reviewed and updated in line with current best practice, in accordance with HSE document on Safeguarding Vulnerable Persons at Risk of Abuse.

Proposed Timescale: 14/02/2016

Theme:

Governance, Leadership and Management

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

The copy of the duty roster did not include the exact hours worked by all staff and did not include the names of the volunteer sisters from the congregation working on each floor.

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 Duty Roster has been amended to include exact hours staff are working and also to

include the names of the sisters on each unit.

Proposed Timescale: 31/01/2016

Theme:

Governance, Leadership and Management

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

The residents' medical records were not easily accessible to staff nurses on the floors.

6. Action Required:

Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

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

Transferring Doctors files to units with Residents Care Plans.

Proposed Timescale: 31/01/2016

Theme:

Governance, Leadership and Management

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

Residents' nursing and medical documents were not filed in chronological order and therefore were not easy to retrieve.

7. Action Required:

Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

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

Re-organise medical and Nursing notes in chronological order.

Proposed Timescale: 14/02/2016

Theme:

Governance, Leadership and Management

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

A record of of all incidents of pressure ulcers and treatment provided to the resident was not available for review.

8. 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:

We will maintain accurate records immediately and in the future adding a more detailed wound chart and will keep a record of any pressure ulcers or wounds on our monthly key performance indicator.

Proposed Timescale: 14/02/2016

Theme:

Governance, Leadership and Management

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

The daily nurses' record for each resident did not always reflect the exact condition of the resident and treatment given by the nurse on duty and was not linked to the residents nursing care plan.

9. 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:

Nursing Staff are in the process of having an update on Care Planning. Care plans to be up-dated four monthly as required. Duty nurses to document any changes in resident's level of care and to change care plans accordingly.

Proposed Timescale: 29/02/2016

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

There was no link evident between assessments conducted on a resident who exhibited challenging behaviour and the care plan in place to manage such behaviour. The care plan in place did not contain sufficient guidance on how to respond to and manage such behaviours.

10. Action Required:

Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as

possible, in a manner that is not restrictive.

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

Update all staff training on challenging behaviour. Policy to be re-read and signed. Making staff aware of the homes Policy on dealing with challenging behaviour. Update care plan to reflect and respond to the management of challenging behaviour.

Proposed Timescale: 14/02/2016

Theme:

Safe care and support

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

Restraint is not being used in line with the National policy or with best practice guidelines.

11. 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:

Re-read our Policy on Restraint so as to ensure that it is in line and in accordance with the National Policy on Restraint using alternative methods, crash mats, Low low beds, alarm system etc.

Proposed Timescale: 29/02/2016

Theme:

Safe care and support

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

One of the volunteers had not attended training on safeguarding and responding to suspicions or allegations of abuse.

12. Action Required:

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

Volunteers to have an up-date on abuse. All the sisters previous have had a course on Safeguarding Vulnerable Persons at risk from Abuse.

Proposed Timescale: 29/02/2016

Theme:

Safe care and support

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

The overall procedures in place for investigation of allegations of abuse were not sufficiently comprehensive as the investigation report into an allegation did not clearly demonstrate how the final conclusion was reached.

13. Action Required:

Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.

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

Regarding alleged cases of abuse we will ensure in future that investigations will be conducted in accordance with updated policy and all detailed records kept, showing how we reached a conclusion to the situation. We will re-read our policy on the risk of abuse.

Proposed Timescale: 31/01/2016

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 risk management policy made available to the inspectors on the day of the inspection did not include the measures and actions in place to control the risk of abuse as required by the Regulations.

14. Action Required:

Under Regulation 26(1)(c)(i) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.

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

Staff have received training on Abuse. On commencing employment all staff are made aware of the policy on abuse and sign to the effect that they have read and understood the Home's Policy and Procedure on abuse. Vigilance is encouraged and any concern promptly reported. Management will deal with information appropriately and in accordance with Regulation 26 (1) As set out in the risk management policy Schedule 5. The monthly audits will be another means of identify the risks. We will also refer to Safeguarding Vulnerable Adults at Risk of Abuse National Policy and Procedures.

Proposed Timescale: 29/02/2016

Theme:

Safe care and support

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

There was no evidence that there was an ongoing process in place within the centre to identify hazards and assess risks. There was no local risk register available for the centre.

15. Action Required:

Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

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

A Risk Register has been compiled to identify hazards and assess risks. This register can be obtained on each unit reflecting various hazards that could occur.

Proposed Timescale: 31/01/2016

Theme:

Safe care and support

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

Staff files reviewed by the inspector did not indicate that all staff had received suitable training relating to fire prevention and evacuation procedures. Staff knowledge relating to evacuation procedures was not consistent.

16. Action Required:

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

Update with maintenance officer the current Fire procedure for the home.
Staff training records on computer. Fire training up-date commencing on the 19th of January 2016 for all staff members. The Fire Officer gave this training which was given over a period of four days.

Proposed Timescale: 29/02/2016

Theme:

Safe care and support

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

Records of fire drills maintained in the centre were not sufficiently detailed and did not provide assurance that staff were fully aware of the procedure to evacuate residents in the event of a fire.

17. 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:

Arranging with Maintenance Officer to review all Fire Procedure and document accordingly. Staff training on each unit is commencing on Thursday the 14.01.2016

Proposed Timescale: 29/02/2016

Theme:

Safe care and support

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

There was limited availability of assistive equipment to assist in the evacuation of residents.

18. 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:

Frail residents and those more or less permanently in bed will have Ski sheets in place under their mattress for easy evacuation in the event of a fire occurring. Each unit will also have their supply of Ski sheets in an emergency, we have purchased 20 Ski sheets.

Proposed Timescale: 31/01/2016

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:

Dates of opening were not consistently indicated on prescribed eye drops and liquids to

indicate the subsequent expiry dates.

19. 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:

All medication and supplements dated when opened. Medication management training will be given to nursing staff which will reflect the national legislation on the safe handling of medication.

Proposed Timescale: 31/01/2016

Theme:

Safe care and support

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

The administration records for one resident's PRN pain relief medicine indicated that the medicine had been administered twice within a three hour time interval on two occasions in November, which was outside the recommended minimum dosing interval of four hours for this particular medicine.

20. 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:

Meeting with nurses and to highlight the importance of the safe handling (administration) of medication and gave recommendations on the above. Nurses reminded of the requirement to update medication management annually.

Proposed Timescale: 31/01/2016

Theme:

Safe care and support

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

The prescription sheets in use within the centre were not sufficiently clear and did not contain all the required information as outlined below:

- original prescription sheets were not in place for all residents (photocopies were being used).
- a number of the prescription sheets were not easy to read/interpret
- 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 on the PRN (as required) medicines to indicate the circumstances in which these medicines were to be administered to ensure consistent administration practice by staff.
- crushing was not indicated for each individual medicine on the prescription sheet
- each medicine on the prescription sheet was not being signed for individually by the prescriber.

21. 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:

GP informed regarding updating of Cardex as required, will follow up what is recommended. Doctor will liaise with pharmacist as how best to achieve this.

Proposed Timescale: 29/02/2016

Outcome 10: Notification of Incidents

Theme:

Safe care and support

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

The Authority had not been informed on two occasions of incidents which were notifiable within three working days.

22. Action Required:

Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

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

Already informed December 2015 and continue to do so in the future.

Proposed Timescale: 14/02/2016

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

Residents were not being comprehensively assessed by staff nurses.

23. Action Required:

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

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

A comprehensive assessment is carried out on each resident within 48 hours of admission, by a staff nurse, resident and next of kin.

Care plans are reviewed every 4 month or when there is a change in the resident's level of care.

Proposed Timescale: On going as stated above

Proposed Timescale:

Theme:

Effective care and support

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

Care plan in place did not reflect the assessed needs of residents, or were not updated to reflect advice from allied health care professionals.

24. 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:

Nutritional Care plans to be updated following SALT and Dietician review.

Chef to be habitually informed and our menus will be reviewed by an external company who have Dieticians.

Proposed Timescale: 29/02/2016

Theme:

Effective care and support

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

A high standard of evidence based nursing care was not bring provided to residents.

Poor care practices included manual handling practices, incontinence care and

management of pressure sores, including appropriate documentation of wound progress and staff nurses not reporting pressure ulcers to the person in charge.

25. 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:

Incontinence training to be arranged for all care staff.

Update our manual handling training.

We have purchased more sliding sheets, sufficient for needs on the units.

It has been highlighted to all nurses the necessity and importance of reporting to the PIC any pressure ulcers, the progress and good practice of wound management.

A new wound chart has been inserted in the care plan and explanation has been given to all nursing staff.

Proposed Timescale: 25/03/2016

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 designated centre to ensure the needs of the residents, assessed in accordance with regulation 5, were met.

26. 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:

Registered nurse on each floor plus healthcare assistants who all have Fetac 5 or Care of the elderly Certificates, Sisters also have the same level of training.

Review dependency levels and logistics of building.

We are currently advertising for staff nurses and CNM

Proposed Timescale: 29/02/2016 and ongoing.

Proposed Timescale: 29/02/2016

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 was not adequate to detect that non-evidence based care being delivered.

27. 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:

Carers supervised by nurses, sisters and care workers all work together as a team. Sisters have qualifications of Fetac 5 in Care. Clinical Supervision is carried out by nurses, ancillary workers are also supervised by sisters. Currently advertising for more clinical staff.

Proposed Timescale: On going.

Proposed Timescale:

Theme:

Workforce

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

The person in charge is not communicating directly with each team of staff on each floor.

28. 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:

We are in the process of reviewing and changing the morning report to facilitate good communication throughout the home.

The PIC receives the report each morning from the nurses and visits throughout the day the units. She also received from the ADON at the end of her duty - a daily report. We will appoint a CNM to facilitate the work load.

Proposed Timescale: 14/02/2016

Theme:

Workforce

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

There was no system in place (such as a training matrix system) to identify the training needs of staff to ensure all staff had received the required mandatory training.

29. Action Required:

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

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

Yearly Training Matrix will be put in place.

Proposed Timescale: 31/01/2016

Theme:

Workforce

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

The volunteer sisters from the congregation working on each floor did not have their roles and responsibilities clearly outlined.

30. Action Required:

Under Regulation 30(a) you are required to: Set out in writing the roles and responsibilities of people involved on a voluntary basis with the designated centre.

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

The Sisters role is in a supervisory capacity on each unit. Working in collaboration with the staff, to achieve the highest standard of care to the residents. They all have training in Care of the Elderly. We are in the process of defining their role and responsibility in writing.

Proposed Timescale: 29/02/2016