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Sacred Heart Hospital, OSV-0000549, 23 January 2018

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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 Hospital
Centre ID:	OSV-0000549
Centre address:	Old Dublin Road, Carlow, Carlow.
Telephone number:	059 913 6486
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Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Lead inspector:	Ide Cronin
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	61
Number of vacancies on the date of inspection:	16

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.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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 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 inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
23 January 2018 09:30	23 January 2018 16:00
24 January 2018 09:05	24 January 2018 13:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Compliant
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Major
Outcome 13: Complaints procedures	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Major
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

An application was received by the Health Information and Quality Authority (HIQA) to renew the registration of this designated centre. Prior to the inspection the provider was requested to submit relevant documentation to HIQA. The inspector reviewed this documentation, ascertained the views of residents, relatives and staff members, observed practices and reviewed records as required by the legislation.

There was a clearly defined management structure that identified the lines of authority and accountability. Persons participating in the management of the centre demonstrated knowledge of the legislation, regulations and standards underpinning residential care. They facilitated the inspection process and had all the necessary documentation available for inspection which was maintained in accordance with legislation. Day to day management responsibilities are with the person in charge and assistant director of nursing. Residents who spoke with the inspector were very complimentary about the care and support provided by staff and management.

A number of completed HIQA questionnaires were reviewed following the inspection. The comments in the questionnaires were positive and revealed high satisfaction levels with staff, care provided, food and access to meaningful activity. Community and family involvement were encouraged.

Previous inspections dating back to 2015 had identified that some aspects of the physical environment were not suitable for the purpose of achieving the aims and objectives as set out in the statement of purpose. Measures had been taken to reduce the number of beds in multi-occupancy rooms. However, effective action had not been taken to address non-compliances relating to other aspects of the premises. In the Sacred Heart unit the dining/day room space was combined. Therefore there was no separate area where residents could watch television or chat privately. The dining area in this unit could not cater for all residents to enjoy a dining experience as it was too small to accommodate all residents as observed by the inspector. There was very limited personal storage space for residents and their individual personal possessions on all three units. These issues were discussed with the provider nominee at the post inspection feedback meeting who accepted the inspector's judgment of major non-compliance.

The inspector was satisfied that residents received a good standard of care that reflected evidence based practice. Staff were observed to be respectful, cheerful and engaged with residents. Staff were up-to-date with training on the required topics of adult protection, fire safety and moving and handling. There was also a comprehensive training programme in place which reflected up-to-date evidence based practice in older persons.

There were arrangements for residents to receive primary care services and access to allied health professionals was sourced in a timely way when required. The inspector found that there was an adequate allocation of staff with relevant skills and experience to meet the needs of residents on the days of inspection.

Overall there was a good level of compliance with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Standards for Residential Care Settings for Older People in Ireland. In particular there was a good system of governance and an emphasis on continual improvement.

The findings of this inspection are discussed in the body of the report and three actions required are included in the action plan at the end for response

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 Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The statement of purpose set out the services and facilities provided in the designated centre and contained all the requirements of Schedule 1 of the regulations. It was kept up-to-date and the inspector found that the way services were delivered reflected the aims and objectives that were outlined in the statement of purpose.

The person in charge understood that it was necessary to keep the document under review and notify the Chief Inspector in writing before changes could be made which would affect the purpose and function of the centre.

Judgment:

Compliant

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 arrangements in place reflected the information available in the statement of purpose and the evidence collated during this inspection indicated that the centre was managed effectively and was appropriately resourced to meet the needs of residents. There was a formal management structure in place and the lines of accountability and authority were adhered to in day to day practice. Staff were aware of who was in charge and knew how to report through the management structure.

Systems were and in place to review and monitor aspects of the quality of care. A schedule was in place to inform frequency of auditing and quality and safety review in various key areas. Clinical audits were carried out that analysed accidents, complaints, medicine management issues/errors, skin integrity, care plans and nutritional risk .This information was available for inspection. There was a low level of serious incidents, accidents and complaints were reported. The person in charge described arrangements that were in place to ensure good governance in the centre. These included regular scheduled management meetings with the provider nominee, health and safety meetings, fire safety and departmental meetings. The person in charge was supported by an assistant director of nursing and clinical nurse managers on each unit.

Systems were in place to ensure that the service provided met residents' needs, was safe, effectively managed and monitored. There was a residents' committee that met regularly and the inspector observed that the regular meetings gave them a forum to express their views. Satisfaction surveys had been completed which indicated for the most part overall satisfaction with the services provided.

An annual review of the quality and safety of care had been completed for 2017 and it informed the service plan for 2018 as observed by the inspector. There were adequate resources deployed to meet the needs of residents in relation to staff, training opportunities, equipment and ancillary services to ensure appropriate care was delivered to residents. There was a plan for ongoing training in 2018 which was comprehensive. The person in charge and assistant director of nursing were facilitators for the National Frailty Programme and were delivering on-site training to all staff. Staff spoke very highly of the management team and of training opportunities available to them.

Judgment:
Compliant

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 changed since the last inspection. She is a registered nurse with the required experience in the area of nursing older people who works full-time in the centre. She is supported in her role by an assistant director of nursing and clinical nurse managers. The person in charge demonstrated that she had appropriate knowledge of the regulations and standards that govern designated centres and the care and welfare of residents. Her training on the mandatory topics required by the regulations was up to date.

During the inspection the person in charge demonstrated a commitment to ensuring a good standard of care to residents and a positive attitude to regulation. All documentation requested by the inspector was readily available. The person in charge along with the management team demonstrated a clear commitment to delivering quality care to residents, while continually striving for excellence.

Judgment:

Compliant

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):

No actions were required from the previous inspection.

Findings:

The inspector found that all reasonable measures were in place to safeguard all residents from abuse.

There was a policy in place to inform prevention, recognition, reporting and responding to allegations or suspicions of abuse. All staff had attended training on protection of vulnerable adults. There were designated safeguarding trainers on site. Staff spoken with by the inspector were knowledgeable regarding abuse and were aware of their responsibility to report any incidents, allegations or suspicions of abuse. The provider and person in charge ensured that there were no barriers to disclosing incidents or allegations of abuse. Residents spoken with on the days of the inspection said that they felt very safe in the centre and complimented the staff looking after them. All staff interactions with residents observed by the inspector were respectful, supportive and kind. The inspector saw that the person in charge involved external advocacy services such as SAGE for residents.

There were policies in place on responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) and the use of restrictive practices. Supporting assessment tools were available. Staff spoken with were familiar with appropriate interventions to use to respond to residents' behaviour. The inspector was informed that changes in behaviour were analysed through a reflective cycle for possible trends which would inform reviews by the GP or psychiatric team. The use of the reflective cycle also enabled staff to understand the progressive nature of dementia. There was evidence that residents with dementia and responsive behaviours were appropriately referred and reviewed by specialist psychiatric services.

Staff had received training in responsive behaviours. Through observation and review of care plans it was evidenced staff were knowledgeable of residents' needs and provided support that promoted a positive approach to with physical and psychological symptoms of dementia (BPSD). Staff were seen to reassure residents and divert attention appropriately to reduce anxieties. No p.r.n psychotropic medications were administered to residents for management of symptoms of their dementia.

There was a policy on the management of restraint which was based on national policy. A restraint register was in place. The centre aimed to promote a restraint free environment that was reflected in practice as observed by the inspector. There was a very low percentage of restraint in use in all units as observed by the inspector

Risk assessments had been completed for all bedrails in use and alternatives trialled were also documented. Bedrail safety checks were in place and the inspector saw that these were consistently recorded. Restraint assessments were reviewed on a regular basis as observed by the inspector. There was evidence that alternatives to bedrails, such as low-level beds and sensor alarms, were trialled in consultation with residents or their families as indicated. However, consent for use of bedrails was not consistently recorded on a unit as observed by the inspector.

Judgment:
Substantially Compliant

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):
This was the centre's first inspection by the Authority.

Findings:
The centre had policies and procedures relating to health and safety that included a health and safety statement and risk management policies to include items set out in

Regulation 26(1). There were policies and procedures in place for responding to major incidents.

Arrangements were in place for investigating and learning from audits, incidents and adverse events involving residents. Measures and actions were taken to prevent incidents included increased supervision, activity and support equipment. A risk register was maintained that assessed/rated identified risks. Control measures were put in place following assessments and implemented to promote resident safety. The management team completed regular reviews of incidents and accidents involving residents to identify trends, the key cause or likely factors in order to inform control measures.

The inspector viewed the fire safety measures and found that the arrangements in place met legislative requirements. There was a fire safety and health and safety committee in place. The training records confirmed that all staff had received fire safety training and staff who spoke with the inspector knew what action to take in the event of a fire. The fire training was supplemented by fire drills.

There were fire safety action signs on display throughout the centre. These signs were clear and displayed prominently throughout the units. There were maintenance records that conveyed the fire equipment had been regularly serviced. The fire alarm was serviced quarterly as required and emergency lights and extinguishers were serviced annually on a contract basis. The inspector found that fire exits were clear and unobstructed during the inspection. There were procedures to undertake and record safety checks of fire extinguishers, the fire panel and the fire escape routes. The records reviewed indicated that checks were up to date.

The procedures in place for the prevention and control of infection were satisfactory. For example, hand gels were in place and hand-washing facilities were easily accessible. There was a contract in place for the disposal of clinical waste. Staff were trained in moving and handling of residents. Training records viewed by the inspector confirmed this.

Judgment:
Compliant

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 operation policies relating to the ordering, prescribing, storing and administration of medicines to residents and disposal of unused or out-of-date medicines. The policies had been reviewed with input from the pharmacist since the last inspection. The inspector saw that the pharmacist also monitored medication safety incidents. Medication prescriptions and administration records were complete in accordance with professional standards.

The inspector reviewed a sample of residents' individual medicine prescription charts and there was evidence that residents' prescriptions were reviewed at least three monthly by a medical practitioner. The pharmacist reviewed regular medicines on a monthly basis and a three monthly review of all p.r.n medicines (a medicine only taken as the need arises).

The pharmacist, GP, management and nursing team attended three monthly multidisciplinary team reviews in relation to medicines management. There was a community intervention team available to residents to administer subcutaneous fluids to treat dehydration and administer intravenous medication in order to avoid unnecessary hospital admissions. Regular medicine management audits were carried out as observed by the inspector.

All medicines were stored in within locked trolleys, presses or a fridge. All controlled (MDA) medicines were stored appropriately, and a register of these medicines was maintained with the stock balances seen checked and signed by two nurses at the end and beginning of a working shift. A system was in place for reviewing and monitoring safe medicine management practices and reporting any errors. The inspector saw that the temperatures of the fridges used for storing medication that required refrigeration were checked daily.

There was a good system in place to ensure that the pharmacist was facilitated to meet the obligations in line with guidance issued by the Pharmaceutical Society of Ireland, including the provision of personal pharmaceutical care to residents.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

There was evidence that the wellbeing and welfare of residents was being maintained through the provision of a high standard of nursing, medical and social care. Residents had access to general practitioner (GP) services and there was evidence of medical reviews at least three monthly and more frequently when required. A review of residents' medical notes showed that GPs visited the centre to review residents and medications on a regular basis. Medicines were also reviewed by the pharmacist to ensure optimum therapeutic values.

There were comprehensive assessments completed following admission and a range of evidenced based assessment tools were used to determine care interventions and risk in relation to areas that included falls, vulnerability to the development of pressure sores, poor nutrition and evidence of cognitive decline or memory problems.

The arrangements to meet residents' assessed needs were set out in individual care plans. The care plans provided good guidance for staff and interventions outlined were being adhered to so that residents' welfare was protected.

The care and treatment available to residents reflected the nature and extent of their needs. It was evident that the clinical care requirements of residents were addressed. For example: residents with wounds or a history of falls, diabetics, those on particular medicines, specific feeding regimes and residents with behaviour changes, were clinically assessed and had appropriate care plans in place to guide and inform staff.

There was evidence that residents were actively involved in the assessment and care planning process and that care plans were initiated within 48 hours of the resident's admission detailing their needs and choices. Care plans reviewed reflected that care was delivered to the resident according to the care plan. The inspector found that residents' care plans were reviewed regularly. Residents were aware of the care plan system and stated that their care plan had been discussed with them.

Access to allied health professionals such as speech and language therapists, dietitians, occupational therapists and staff from mental health services for older people was timely when referrals were made. There was also access to onsite clinics such as diabetes and memory clinics. Residents and staff informed the inspectors that they were satisfied with the current healthcare arrangements and service provision.

There were written policies and procedures in place for end-of-life care. Staff provided end-of-life care to residents with the support of their GP and the community palliative care team. A pain assessment tool for residents, including residents who were non-verbal was available and in use to support pain management. A system was developed to ensure residents with a do not attempt resuscitation (DNAR) status in place have the status regularly reviewed to assess the validity of the clinical judgment on an ongoing basis.

Judgment:

Compliant

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Effective care and support

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

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

Findings:

The centre is a single-storey premises located within close proximity to the local town centre. It is divided into three units. The provider had not taken the required actions to address non compliances in relation inadequate wardrobe space in the three units and confined dining facilities in the Sacred Heart Unit.

The centre is registered for 77 residents but the provider has reduced the number of beds in multi-occupancy rooms and the report sets out the current numbers accommodated in the three units

The Sacred Heart unit is a 26-bedded unit which accommodated both female and male residents. Residents' accommodation comprises of five four-bedded wards, two single en-suite rooms and two double en-suite room. There are seven toilets and three showers in total. A dining/sitting room and a smoking room are available. However, the inspector observed that the dining area was too small to cater for all residents to benefit from a dining experience. On the first day of inspection nine residents had their meal there and the remainder had their meal beside their bed. The room was narrow and the inspector observed that it was difficult to accommodate all residents due to large chairs used by some residents and also lack of floor space. It has been identified in all inspection reports dating back to 2015 that separate dining/ communal space is required in this unit. There is a sluice room, and storage rooms. There is a nursing office and a medical room.

St Clare's is a 22-bedded unit for residents experiencing dementia, mental health difficulties and other medical conditions. 21 beds are designated as long stay and there is one respite bed. There are five four-bedded wards. There is one single bedroom with en-suite, shower and wash-hand basin for the rotating respite resident. There is also a single bedroom with en-suite toilet, shower and wash hand basin. Apart from the en suite facilities there are seven toilets and three showers. A sitting/dining room has a divider in place. A smoking room and storage rooms, nursing office and a medical room

which is used to store the care plans and a multisensory room are available.

St James-Rehabilitation is a 24-bedded mixed unit with accommodation for ten long-stay residents and 14 rehabilitation residents. Residents are accommodated in five four-bedded wards, one two bedded en-suite and two single en-suite rooms. Apart from the en-suite facilities there are nine toilets and five showers. There is one dining and sitting room. There is also a small sitting room, a smoking room and storage rooms. There is a nursing office and a medical room. There is a secure garden attached to this unit and all residents can access the other garden areas.

The centre was clean, comfortable, welcoming and well maintained both internally and externally. There were handrails and safe floor covering throughout the centre. Appropriate assistive equipment was provided to meet residents' needs such as hoists, seating, specialised beds and mattresses.

The wardrobe space and storage space for personal possessions in the three units was found to be inadequate, otherwise the inspector found the standard of accommodation was adequate in St. Claire's and St. James-Rehabilitation units. The issue of inadequate dining facilities in the Sacred Heart Unit and its impact on residents' quality of life has been highlighted to the registered provider since 2015. Therefore the inspector concluded that this outcome was major non-compliant.

Judgment:

Non Compliant - Major

Outcome 13: Complaints procedures

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Policies and procedures which comply with legislative requirements were in place for the management of complaints. Formal complaint procedures and appeals details were outlined in the HSE complaints policy 'your service your say'. Residents told the inspector that they would have no hesitation reporting an issue to the nurse manager.

On review of the record of complaints there was evidence that all complaints were documented, investigated and outcomes recorded. Complainants were notified of the outcomes and a review was conducted to ascertain the satisfaction of the complainant further to issues being resolved.

All complaints were found to be resolved in a timely way. The independent advocacy service was advertised and utilised as observed by the inspector.

Judgment:

Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

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

Theme:

Person-centred care and support

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

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

Findings:

The inspector found that residents were consulted regarding the planning and organisation of the centre. There was a residents' forum in place and the inspector also reviewed minutes of previous meetings. 'This is me' and personal life histories were completed for all residents as observed by the inspector. Choice was respected and residents were asked how they wished to spend their day. Control over their daily life was also facilitated in terms of times of rising or returning to bed and whether they wished to stay in their room or spend time with others in the communal rooms.

The inspector observed that where residents required supervision in communal areas that staff used these opportunities to engage in a meaningful and person-centred way. Residents appeared to be familiar with staff. At meal times staff were observed speaking to residents, and where support to eat and drink was being provided, it was done in a discreet way.

Residents had access to a variety of national and local newspapers and magazines to reflect their cultural interests and heritage. Arrangements were in place to meet residents spiritual needs and engage in religious practices. Residents who wished to do so could attend religious services and receive the Eucharist in the centre on a regular basis. Residents were registered to vote.

Arrangements were provided for residents to attend family occasions and opportunities to socialise and link with the wider community by arranged outings and visits by members from the local community was facilitated. Both residents and staff confirmed to the inspector that outings took place and the inspector saw photographs displayed in each unit. All residents had access to a secure outdoor space with seating available. Residents were observed to move around freely and were appropriately supported by

staff while mobilising if required.

A varied programme of quality recreational activities were provided for residents. There were a number of staff- 2.6 whole-time equivalents designated to activities over a seven day period. Entertainment from external sources was also arranged such as live musicians and visits from transition year students. In-house activities included arts and crafts, bingo, exercise sessions, card games, baking and Sonas sessions (a therapeutic activity for residents with dementia). The inspector spoke with the activities coordinators and found that they were very enthusiastic. They informed the inspector of their forthcoming plans for the year such as setting up the mens shed with in conjunction with Carlow Development Group.

However, the inspector also observed that storage space for personal belongings was limited in all units. Wardrobes were very small and as a result clothes were stored in plastic storage boxes underneath wardrobes. This had also been highlighted as an issue in satisfaction surveys viewed by the inspector and in the minutes of the last two residents' forum meetings. Three questionnaires also reviewed by the inspector following inspection also highlighted the lack of space for residents' clothes in the wardrobes. The inspector also spoke with residents on the second day of inspection and residents told the inspector that the wardrobes were small. The issue of inadequate wardrobe space for residents has been highlighted to the registered provider since 2015 and therefore the inspector concluded that this outcome was major non-compliant.

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 inspector formed the judgement through observation, speaking with staff and review of documentation that there was an adequate complement of nursing and care staff with the required skills and experience to meet the assessed needs of residents taking account of the purpose and size of the designated centre. Staff who spoke with

the inspector said that there was sufficient staff on duty day and night. Residents who spoke with the inspector did not raise any concerns with staffing levels.

Observations confirmed staff were deployed to meet resident's needs. Staff told the inspector that there was good team spirit amongst the staff and everyone worked together. The inspector saw that copies of the standards, policies and procedures and best practice guidelines were available to staff on all units.

Staff spoken with were aware of the reporting mechanisms and the line management system. Staff demonstrated a clear understanding of their role and responsibilities. Staff meetings were held regularly and staff stated that communication between staff and management was clear and unambiguous.

Training records revealed that there was a very good level of appropriate and mandatory training provided to staff. Staff spoken with told the inspector their learning and development needs were being met. In addition, staff were supported to deliver care that reflected contemporary evidence-based practice. Registration details with An Bord Altranais agus Cnaimhseachais na hEireann were maintained for staff.

There was a recruitment policy in place and staff recruitment was in line with the regulations. The person in charge said that all staff were Garda vetted. Good supervision practices were in place with the nurses visible on the floor providing guidance to staff and monitoring the care delivered to residents. Residents told the inspector that they were very well cared for by staff. A sample of staff files was viewed by the inspector. These were seen to contain all the regulatory requirements set out in Schedule 2 of the regulations.

Judgment:
Compliant

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:

Ide Cronin
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 Hospital
Centre ID:	OSV-0000549
Date of inspection:	23 & 24/01/2018
Date of response:	28/03/2018

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 07: Safeguarding and Safety

Theme:

Safe care and support

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

Consent for use of bedrails was not consistently recorded on a unit as observed by the inspector.

1. 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

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

website of the Department of Health from time to time.

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

Consent for use of bedrails has been consistently recorded in all cases.

Proposed Timescale: 07/02/2018

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

It has been identified in all inspection reports dating back to 2015 that separate dining/communal space is required in this unit. The dining area was too small to cater for 26 residents to benefit from a dining experience and there was no separate sitting area for residents to relax in.

2. Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

Sacred Heart, Carlow has been approved under the National Capital Development plan for works to include a new day dining room , refurbishment of shower rooms and alterations to allow for more single room accommodation. The funding to do this allows for the design team to be tendered for, appointed and design to be completed in 2018. Building works will commence in Q1 2019

In the interim we have reviewed our dining arrangements for residents and now have 2 sittings for meal times which allows residents to access the dining room for meals should they wish to do so.

Proposed Timescale: 2018 Tender and Appointment of Design Team
2019 completion of building works/alterations.

Proposed Timescale: 31/12/2019

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

The inspector observed that storage space for personal belongings was limited. Wardrobes were very small and as a result clothes were stored in plastic storage boxes underneath wardrobes. The issue of inadequate wardrobe space for residents has been highlighted to the registered provider since 2015 and therefore the inspector concluded that this outcome was major non-compliant.

3. Action Required:

Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

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

New wardrobes will be commissioned in order to give larger wardrobes to each resident in the long stay units.

Proposed Timescale: 30/08/2018