Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Sacred Heart Hospital Castlebar
Name of provider:	Health Service Executive
Address of centre:	Pontoon Road, Castlebar, Mayo
Type of inspection:	Unannounced
Date of inspection:	22 September 2021
Centre ID:	OSV-0005730
Fieldwork ID:	MON-0033800

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Sacred Heart Hospital is a purpose-built facility completed in 2018 that can accommodate 74 residents who require long-term residential care. Care is provided for people with a range of needs: low, medium, high and maximum dependency and people who have dementia or palliative care needs. This centre is a modern two-storey building and is located adjacent to the original Sacred Heart Hospital premises. It is a short drive from shops and business premises in Castlebar. It is comprised of two self contained units. The Ross unit is located on the ground floor and the Carra unit on the upper floor. There is lift access between floors. There are 35 single rooms and one double room, all with full en-suite facilities, on each floor. The centre has a large safe garden area off the ground floor. This has several access points and was well-cultivated with flowers, trees and shrubs to make it interesting for residents. The philosophy of care as described in the statement of purpose is to use a holistic approach in partnership with residents and their families to meet residents' health and individual needs in a sensitive and caring manner while balancing risk with safety.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	67

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 22 September 2021	10:00hrs to 17:30hrs	Catherine Sweeney	Lead
Wednesday 22 September 2021	10:00hrs to 17:30hrs	Lorraine Wall	Support

What residents told us and what inspectors observed

Inspectors spoke with six residents on the day of the inspection. Overall, residents reported that they enjoyed living in the centre and that the staff were always kind and attentive. Inspectors observed staff communicating respectfully with residents. Staff appeared to know the residents well and residents appeared relaxed and comfortable in the company of staff.

Residents stated that, 'while there was no place like home, this was a nice place to live.' They explained that they felt safe and knew who to speak with if they had any issues or concerns.

One resident told the inspectors that they enjoyed getting up in the morning at a time of their choosing and going to bed when they wished. They added that this was very important to them and it allowed them to maintain their independence.

The centre was observed to be well designed, with attractive fittings and furnishings. The two-storey purpose-built centre surrounded a large internal courtyard. Residents had unrestricted access to the courtyard and were observed using the outside space throughout the day of the inspection. The communal areas in the centre were decorated in a person-centred and appropriate manner. Wall murals and pictures were used effectively to capture residents personal interests and preferences. For example, a ceramics wall mural depicting a clothes line with subtle details about past and current residents added to the person-centred and homely feel of the centre. Some residents had access to a personal garden which the residents themselves maintained.

Orientation boards with clocks, calendars and the activity schedule for the day were displayed around the centre. This facilitated residents to be aware of the time and date, and to be informed of any social activities taking place.

Residents were observed to have a high level of social engagement during the early part of the day. Inspectors observed residents doing daily exercises, playing bingo in groups and engaging with each other while walking in the centre and in the outdoor areas. Following the midday meal, inspectors observed that the level of activity decreased. Although some residents with more complex needs were observed to receive one-to-one time with the activity coordinator at this time, some residents told the inspectors that they found the evenings long, with not much to do.

Residents told the inspectors that they enjoyed the food in the centre. There was always a choice at meal times and drinks and snacks were available throughout the day.

A relative who was visiting the centre on the day of the inspection told the inspectors that the care their relative received was of a high standard. They explained that there was clear communication with them in relation to care and that

they were kept up-to-date with any changes in the centre, particularly in relation to COVID-19. They told the inspectors that staff were kind, friendly and welcoming and were always observed to treat the residents very well.

Inspectors observed both indoor and outdoor visits being facilitated throughout the day of the inspection. Systems such as temperature and symptom checks, mask wearing and social distancing, were in place to ensure residents could meet with their family and friends safely.

Capacity and capability

This was an unannounced risk inspection by inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and to follow up on action taken by the provider following the findings of the last inspection on 27 June 2019.

Inspectors also followed up on the action taken by the provider in relation to infection prevention and control. The centre had recovered from an outbreak of COVID-19 in January 2021. Over the course of the outbreak, 45 residents and 57 staff tested positive for COVID-19. Sadly, 10 residents died with COVID-19. Inspectors acknowledge that the staff and the residents in the centre had experienced a difficult time and had worked hard to ensure the safety of their residents.

The provider of the centre is the Health Service Executive (HSE). There was a clear management structure supporting the centre. A director of nursing was the person in charge. A general and regional older peoples service manager provided managerial support to the person in charge. Within the centre, the person in charge was supported by an assistant director of nursing and a team of clinical nurse managers. The person in charge was on-site and facilitated this inspection.

The designated centre is located within Sacred Heart Hospital and comprises of two units, the Ross unit and the Carra unit. Each unit was staffed independently with a clinical nurse manager, nurses, carers and support staff.

Overall, the findings of this inspection is that the centre is well managed and that care is delivered to a high standard. Actions from the last inspection had been addressed. The provider had made arrangements to review the infection prevention and control systems and a quality improvement plan was in place. The inspection found areas where improvement was required under regulation 21, records, regulation 23, governance and management, regulation 5, individual assessments and care plans, and regulation 9, residents' rights.

While the overall governance of the centre was satisfactory, the management systems in place in the centre were found to be inconsistent. For example, the provider had a robust system of risk management, infection prevention and control,

and staff communication in place. A review of these systems found that they were well organised, with clear quality improvement plans identified and regularly reviewed. However in contrast, the system in place for clinical and environmental auditing and the nursing documentation system did not provide the assurance that these systems were safe and met the required standards.

A review of the rosters found that staffing levels and skill mix were adequate to meet the assessed needs of the current residents and for the size and layout of the building. While there was adequate levels of health care assistants available for the occupancy of the centre on the day of inspection, the provider was in the process of recruiting health care assistants and had suspended admission to the centre until this recruitment process has been completed

A review of the training records found that all staff had completed a mandatory training programme that included fire safety, manual handling, safeguarding the older adult and regular infection prevention and control training.

A sample of staff files were reviewed and found to contain all the information required under Schedule 2 of the regulations including a Garda Siochana (police) vetting certificate for each staff member. This was a completed action from the last inspection.

The provider had robust systems in place to manage complaints. Inspectors reviewed the complaints policy and procedure, and the complaints register, and found that complaints were managed and recorded in line with the requirements under regulation 34. The complaints procedure was displayed prominently in the centre.

Regulation 15: Staffing

Staffing was found to be adequate to meet the assessed needs of residents accommodated in the centre on the day of the inspection and for the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

All staff had completed mandatory training. Staff spoken with demonstrated an awareness of procedures in relation to fire safety, safeguarding and infection control procedures.

Staff were well supervised in the centre. A team of clinical nurse managers

supported the nursing teams on all shifts including night duty and at the weekends.

Judgment: Compliant

Regulation 21: Records

A review of the nursing documentation system in the centre was required to ensure that the system in place was effective and safe. There was a paper-based documentation system to record the information required in respect of each resident under Schedule 3 of the regulations. The risk to effective and safe care was evidenced by

- clinical assessment for one resident was found in the file of another resident
- past assessments for on-going clinical issues such as wounds were not available for review in the residents file

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a quality improvement schedule in place. Each unit in the centre completed a suite of clinical and environmental audits. However, the information collected for analysis in these audits did not facilitate an appropriate quality improvement plan being developed. For example;

- In a recent three-monthly review of falls, the only information reviewed in the audit was the total amount of falls in the centre. The audit did not include information relating to when, who and why the fall occurred. This meant that an action plan for improvement was based on the number of falls rather than developed to address the potential causes of the falls.
- The oversight of record keeping was not robust as evidenced under regulation 21, records. A review of records and information management was required to ensure the system was safe and effective.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The management of complaints was in line with the requirements under regulation 34.

Judgment: Compliant

Quality and safety

Overall, the quality and safety of care was found to be delivered to a satisfactory standard and met the needs of the residents. Inspectors observed a resident-centred culture in the centre, with residents reporting that they felt safe and well cared for.

As mentioned earlier in this report, the centre experienced an outbreak of COVID-19 in the centre in January 2021. Inspectors reviewed the actions taken by the provider following this outbreak. While there was no post-outbreak report completed, the provider had taken some action to review systems and identify quality improvements. A number of clinical and environmental infection prevention and control audits had been completed since the outbreak. Quality improvements had been identified and some action had been taken to address issues. For example ,

- an infection prevention and control lead had been identified.
- health care assistants now deliver food to the residents rather than kitchen staff, to reduce contact as much as possible.
- Personal Protective Equipment (PPE) supply had been reviewed and a contingency plan had been put in place to access more PPE if required.

The centre was visibly clean and tidy on the day of the inspection. Each unit had a cleaner on duty. Cleaning systems were observed to be in line with the national standards.

The provider had a system in place to manage risk. Clinical and environmental risks were identified, and the action taken to control risks was recorded and regularly reviewed.

Overall, care was observed to be delivered to a high standard. Inspectors found that all residents had a comprehensive assessment of their care needs completed. This assessment guided the development of each residents care plan. All resident had a care plan on file. However, a review of how care was documented was required to ensure that the documentation accurately guided care and reflected the standard of care observed to be delivered. The quality of the care plans reviewed was inconsistent. This was evidenced by

- generic printed care plans with gaps to insert the residents name and personal details were in place for all residents resulting in some care plans being prescriptive and not person-centred.
- multiple care plan interventions for each resident did not facilitate or identify a clear guide to caring for the resident.

There was a medical officer available to residents seven days a week. Residents also

had weekly access to a consultant geriatrician who visited the centre. Furthermore, residents were supported by a team of allied health care professionals including a dietitian, physiotherapist, optician and an occupational therapist. A community palliative care and a psychiatry of later life team also formed part of the multi-disciplinary support for residents. The recommendations made by all the allied health care professionals were incorporated into the residents care plans.

Inspectors found that residents' rights were respected and upheld in the centre. A review of residents meeting notes found that issues brought to the attention of staff were addressed to the satisfaction of the residents. Residents were observed to have access to local and national newspapers, televisions and radio. Visiting was facilitated and observed to be in line with the national guidelines.

A review of the provision of activities in the afternoons and evening was required to ensure the social care needs of all residents were met, as a number of residents told the inspectors that they felt there was little opportunity for activities after midday.

Regulation 11: Visits

A system was in place to ensure that residents had access to visitors, facilitated in a safe manner. Inspectors observed visits taking place throughout the day of inspection. Residents reported that they see their families and friends regularly.

Judgment: Compliant

Regulation 26: Risk management

A risk management policy was in place. The policy contained the requirements under regulation 26. Inspectors reviewed the risk management system which included a risk register and the HSE's National incident management system, where all adverse incidents were logged.

Judgment: Compliant

Regulation 27: Infection control

Overall, the inspectors found that the infection control systems in place were compliant with the requirements under regulation 27.

The centre was observed to be clean and well organised. The inspectors observed good hand hygiene practices by staff with alcohol based hand sanitiser readily

available throughout the centre. Staff demonstrated good practice in relation to personal protective equipment (PPE). Staff completed cleaning schedules which were monitored by the person in charge. This ensured that every area of the centre was cleaned to the appropriate standard.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A review of the quality of the information found in the care plans was required. Inspectors found that the quality of the care plans was inconsistent. Some care plans described resident's care needs and personal preferences in a detailed and person-centred manner, while other plans reviewed lacked the detail required to guide staff to deliver effective, person-centred care. For example, a social care plan for a resident with complex care needs contained minimal detail in relation to the residents personal preferences and needs and did not provider the information required to deliver high quality person-centred care.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were found to be well supported by a both a medical team and appropriate referral to allied health care professionals.

Judgment: Compliant

Regulation 9: Residents' rights

Opportunities for social engagement were facilitated by the activities coordinators. Residents were observed to be social engaged with activities and interaction with each other, particularly during the morning time. Although there was a programme of activity for the afternoon, residents told the inspectors that they found the afternoons long. A review of the activity schedule was required to ensure that it met residents requirements.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Sacred Heart Hospital Castlebar OSV-0005730

Inspection ID: MON-0033800

Date of inspection: 22/09/2021

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Unit Clinical Nurse Managers reviewing all files. All files are currently being audited to ensure correct filing ensues. Past assessments for on-going clinical issues such as wounds now on file reflective of current status. Discussions for electronic documentation system underway with General Manager of Older Peoples Services.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A falls audit is underway. Falls are captured on the NIMS system. Criteria audited from a falls point of view include: Who has fallen and if this is recurrent. Time falls take place and staff on duty to reflect any noted trends. Falls occurring in a specific Unit. All residents have a Falls Risk assessment completed. Those who have a high falls risk have an individualized risk assessment to determine controls put in place to reduce falling, potential injury from falling. Amalgamation of care planning is planned for the process of 4 monthly care plan review. This will reduce the amount of Care Plans on file ensuring ease of reading for health care	

Workers; this will lead to a safer and more effective management of information.
National approval will be required in order to progress

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
A care plan audit has been scheduled. This will determine those in need of further training to ensure Care plans are reflective of resident's personal needs and personal preferences in a detailed and person centered manner.

Amalgamation of care planning is planned for the process of 4 monthly care plan review. This will reduce the amount of Care Plans on file ensuring ease of reading for health care Workers; this will lead to a safer and more effective management of information.

National approval required in order to progress.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
There are currently 3 activities personnel in the Sacred Heart Hospital.

Volunteers have been interviewed and are currently being Garda Vetted. They will engage in meaningful activities for the residents with a focus on afternoon and evening entertainment.

A local artist has been employed to provide art classes two days per week.

A musician also attends the Suites to provide live music to the residents.

Movie evenings have been planned.

A survey is planned for the residents to identify activities they would like, timing of the activities and any suggestions they bring forth will be actioned.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 21(1)	The registered provider shall 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.	Substantially Compliant	Yellow	31/01/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	31/01/2022
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social	Substantially Compliant	Yellow	31/01/2022

	care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	31/01/2022
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	31/01/2022