

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Sacred Heart Residence
<b>Centre ID:</b>	OSV-0000157
<b>Centre address:</b>	Little Sisters of the Poor, Sybil Hill Road, Raheny, Dublin 5.
<b>Telephone number:</b>	01 833 2308
<b>Email address:</b>	ast.raheny@lspireland.com
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Little Sisters of the Poor
<b>Provider Nominee:</b>	Theresa Martin
<b>Lead inspector:</b>	Leone Ewings
<b>Support inspector(s):</b>	Shane Walsh
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	84
<b>Number of vacancies on the date of inspection:</b>	1

## 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 1 day(s).

**The inspection took place over the following dates and times**

From: 27 July 2017 09:30 To: 27 July 2017 18:00

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 01: Statement of Purpose	Substantially Compliant
Outcome 02: Governance and Management	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Substantially Compliant
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Compliant

**Summary of findings from this inspection**

The inspection was carried out in response to the provider's application to renew the certificate of registration. The provider has applied to renew their registration for 86 beds. Unsolicited information and notifications received were also considered as part of this inspection.

The provider and person in charge had fully addressed the seven regulatory breaches from the last inspection on 1 December 2016. This included an immediate action to improve staff recruitment procedures. Improvements had take place with Garda Vetting procedures, governance and record keeping. The inspectors were satisfied that the residents received a good quality service.

As part of this inspection, the inspectors met with residents, relatives and staff members. They observed practices and reviewed documentation such as care plans, audits and management meeting minutes and policies and procedures. All staff were

able to provide clear information to the inspectors when requested.

The inspectors found that residents were supported by a staff team who knew them well. Staff were skilled and experienced in providing health and social care for residents, and had completed relevant training for their roles. Five residents and four relatives provided written feedback to say they were well supported by the staff team, who were kind and treated them respectfully. A review of residents' records showed that relevant assessments were carried and where residents required support, care plans were in place with guidance to staff about how it was to be provided. Overall, staffing in place on the day of the inspection was adequate to meet the assessed needs of residents.

The governance and management systems operated in the centre were seen to be improved. Regular audits were carried out by the management team to ensure that positive outcomes for residents were being achieved, and if improvements were identified actions were agreed and reviewed. Reviews and feedback was sought with residents and relatives to inform improvements. Governance and planning around staff training in fire safety procedures required additional work by the provider to maintain staff competency in this area.

The seven action plans at the end of this report relate to matters which require review to meet the requirements of the Health Act 2007 (Care and welfare for Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland (2016).

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):**

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

**Findings:**

A statement of purpose dated July 2017 (version 8) was in place. This document detailed the aims, objectives and ethos of the service. The information was in line with legislative requirements. However, it required updating with details of the revised organisational structure as notified to HIQA.

**Judgment:**

Substantially 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):**

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

**Findings:**

Actions from the previous inspection had been addressed and improvements maintained. Fire safety procedures and fire maintenance works had now been completed, and related documentation available for inspection.

There was a clearly defined management structure with lines of authority and

accountability. The provider and the person in charge worked in the centre on a fulltime basis. The provider had recently recruited a new manager called the chief nursing officer to improve overall governance and oversight and to oversee training.

A member of the provider's religious order worked on each unit and maintained oversight of household and catering. The unit 'sisters' job role and description was reviewed by the inspectors. They reported to a member of the order also based in the centre.

Staff and residents were familiar with current management arrangements. Residents were complimentary of the management team. Residents told the inspector that they knew the managers and unit sisters by name and they were accessible to talk to at any time. Residents were complimentary about the staff and the service they received. The inspector found that the service was adequately resourced to meet resident needs and increased staffing had been maintained since the previous inspection. The management team had completed all seven action plans from the previous inspection which took place on 1 December 2016.

A new electronic record-keeping system had been introduced and staff were receiving training and supports to fully implement. An audit of care plans was undertaken regularly by the clinical nurse manager. Feedback on this was given to each nurse in order to make improvements in records and as part of monitoring and implementing the new electronic record keeping system. Data was collected in relation to various aspects of the service such as the number of residents with infections, weight loss, pressure-related wounds, bed bound or chair bound residents, bedrails in use and environmental hazards. This data informed management meetings and audit in the centre. For example, the use of bedrails had decreased, and record keeping and assessment had improved.

The inspectors found a low level of incidents and accidents was reported and this was confirmed by a review of records and discussions with residents and staff. There were few complaints since the previous inspection and all were managed in line with the policy and used to inform service improvements.

An annual report detailing the provider's review of the quality and safety of care and quality of life for residents in the centre was completed in 2016 and the action plans had been implemented. This report was now being compiled in consultation with residents and informed the service plan for 2017.

**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
<p><b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.</p> <p><b>Findings:</b> The person in charge had not changed since the time of the last inspection. She was suitably qualified with the skills, knowledge and experience undertaking this role and worked fulltime. She meets all the requirements of the regulations and holds a management course.</p> <p>She is supported in her role by the provider, an assistant director of nursing, chief nursing officer and clinical nurse manager.</p>
<p><b>Judgment:</b> Compliant</p>

<p><b><i>Outcome 05: Documentation to be kept at a designated centre</i></b> <b><i>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.</i></b></p>
<p><b>Theme:</b> Governance, Leadership and Management</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> The action(s) required from the previous inspection were satisfactorily implemented.</p> <p><b>Findings:</b> Actions from the previous inspection had been addressed and improvements maintained and staff files were now compliant. Fire drill records were maintained following the last inspection. However, the provider did not have a robust system in place to identify staff due for refresher training in both fire safety and safeguarding, to plan for additional training. The provider submitted planned training dates for each of these areas following the inspection. However, although dates were now identified a number of staff had not completed mandatory yearly fire safety refresher training.</p> <p>The records as listed in Part 6 of the Regulations were maintained in a manner so as to ensure completeness and accuracy. Overall, a satisfactory standard of record keeping could be evidenced throughout the inspection, and records requested were accessible.</p>

A sample of staff files were reviewed and found to contain all the requirements of schedule 2 of the regulations, including evidence of Garda Vetting disclosures.

The centre was adequately insured against accidents or injury to residents', staff and visitors, as well as loss or damage to a resident's property.

A directory of residents was maintained which contained all of the matters as set out under regulation 19.

The designated centre had all of the written operational policies which had been recently reviewed as required by schedule 5 of the regulations. Policies were evidence-based and guided staff practices.

Records of resident participation in activities needed improvement. It was not clear if they accurately reflected resident participation. Schedule 3 nursing narrative records required review to fully reflect the planned care and daily supports for each resident.

**Judgment:**

Substantially 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:**

There were safe policies and procedures in place around safeguarding residents from abuse, and promoting a positive approach to responsive behaviours. However, some of the supportive care plans reviewed around restraint and responding to responsive behaviours required some improvement. There were some gaps identified in safeguarding/elder abuse training records. Dates for training in September had been identified for staff to complete the refresher training.

There was a policy and procedures in place for the prevention, detection and response to abuse. The reporting structure for reporting alleged abuse was clearly outlined in the policy. The person in charge in the centre was responsible for carrying out an investigation if an allegation of abuse was made. Staff spoken to in the centre were aware of what constitutes abuse and were also clear on what to do and who to report to if they suspected abuse had occurred. Residents spoken to informed the inspectors that



they felt safe in the centre.

The person in charge confirmed that all staff and volunteers had been vetted in the centre, and staff and volunteers files inspected confirmed this was the case.

The inspectors reviewed the care plans of residents' who had responsive behaviours. The care plans did not consistently guide practice on how to de-escalate responsive behaviours. Care plans outlined that staff should be aware of triggers that may cause a residents to display responsive behaviour, however these triggers were not always assessed and documented. When staff were asked about this they seemed knowledgeable and could explain the various triggers. Staff were clearly able to explain to inspectors the de-escalation techniques which could calm residents. However, this information to inform and guide practice was not documented in the care plans reviewed.

There was a risk assessment and a care plan in place for any residents using bed rails, and a policy on the use of restraint. A review of any physical restraints including bedrails took place on a four monthly basis. Staff had received training in the use of any restraints, and was working towards a restraint-free environment. Some reduction in the use of physical restraints was evident, however, further work and training to ensure safe practice and fully implement the National policy was required. For example, the resident restraint assessments reviewed by inspectors, did not in all cases clearly outline any alternatives to bed rails which had been used as part of this review. The records did not clearly evidence as to why they were considered unsuitable, or if the alternatives had been trialled. Staff had informed the inspectors that in some cases the alternatives had not been tried, although this equipment was available for use in the centre.

Resident finances were reviewed and inspectors found that five residents were supported by the provider where they acted as pension agent. The procedures and records maintained by the accounts person were found to be in line with best practice.

**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):**  
No actions were required from the previous inspection.

**Findings:**  
The centre had up-to-date policies in place in relation to health and safety. There were suitable arrangements in place in relation to fire safety. Some improvements were

required with relation to systems in place for provision of fire safety training for all staff.

The centre had an up-to-date safety statement which was signed by a representative of the provider. The statement dealt with any identified risks found to the health and safety of residents, staff and visitors to the centre. A small number of residents used the smoking room which was in the building. Suitable fire resistant furnishings, call bell and ashtrays were in place. This area could be supervised and fire equipment was available in the room. Staff were knowledgeable about what to do in the event of a residents clothing catching alight.

The centre now had a clear policy in relation to fire safety, with evacuation procedures, directions and the designated fire zones displayed throughout the centre. The centre was compartmentalised by regular fire doors. The fire doors were on self closing mechanisms that would shut when the fire alarm sounded. The fire doors also had heat seals and smoke seals to slow the spread of fire or smoke. Fire exits throughout the centre were clearly marked and were clear from any obstruction. Each unit in the centre had primary and secondary routes of evacuation. The provider had notified to HIQA that a successful evacuation of residents from a compartment on the second floor had taken place earlier this year, due to smoke being present in a corridor and activating the alarm. The actions taken were in line with the procedures practices and a full report made and detailed follow up took place to address the cause of the smoke.

Each resident had been assessed based on their ability to evacuate independently or with the assistance of staff. Their personal emergency evacuation plans were displayed on the back of each resident's door. It outlined how many staff were required to assist the resident and if any equipment was needed to assist the evacuation. Ski sheets evacuation aids were in place under the mattress of all residents assessed as needing them.

The inspectors reviewed the servicing records of the fire alarm and emergency lighting since the last inspection. Both had been serviced on a quarterly basis. There were fire fighting equipment in place throughout the centre and servicing records confirmed that they had been serviced in May 2017. An inspection had been carried out in the centre in June 2017 by the fire authority and any actions outlined had been addressed.

Fire drills were carried out weekly or two weekly. The drills encompassed staff working on both day and night shifts. The records listed the date, time and what occurred in the drill.

All staff spoken to had a very good understanding of the procedure to be followed if the fire alarm sounded. While all staff had completed training in fire safety in 2016, some staff training had not yet been updated for 2017. Dates for additional fire training for 30 staff were booked by the provider for August and September 2017.

There was a policy on infection control which staff demonstrated a good awareness of. There were hand-wash basins and hand sanitisers throughout the centre. Staff were observed to follow good infection control procedures and hand hygiene.

**Judgment:**

Substantially 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):**

No actions were required from the previous inspection.

**Findings:**

Inspectors were satisfied that residents were protected by the designated centres' policies and procedures for medication management. Some improvements were found to be required around the use of prn (as required) psychotropic drugs.

Inspectors reviewed a sample of completed prescription and administration records and saw that they were in line with best practice guidelines. Medicines that required crushing were prescribed as requiring same. Residents medication records also contained records of communications with the pharmacist. For example, staff requesting specific guidelines and information on the preparation of medication had been provided with clear directions on how to prepare, dissolve and administer the medication.

Medications used in the management of diabetes had clear guidelines to support staff in the safe administration of the medicines. Inspectors reviewed practices around PRN (as required) psychotropic drugs and found that residents requiring these drugs had a care plan to support an evidence-based and individual approach to administration. However, nursing and administration records reviewed did not fully outline the steps which had been followed prior to the administration of the drug. The frequency and use of these drugs was not consistently in line with medication management policy, and not sufficiently monitored and evaluated at a multidisciplinary level. Examples of this were discussed with the person in charge and nursing staff during the inspection.

Inspectors observed nurses administering medication to residents. Medications were kept in a locked treatment room, and only nurses can administer medication to residents. Inspectors found that staff adhered to appropriate medication management practices and processes in place for handling medication were safe and in accordance with current guidelines and legislation.

Inspectors reviewed practices around medications that required strict control measures (MDAs). These medications were kept in a secure cabinet in keeping with professional guidelines and nurses maintained a register of these medications. Inspectors reviewed records which demonstrated that the stock balance was checked and signed by two nurses at the change of each shift.

At the time of this inspection, no resident was self administering medication, However,

systems were in place to support residents that may choose to self administer and assessments were in place to enable staff to support residents to self administer.

Systems were in place for reviewing and monitoring safe medication management practices. Medication audit was completed each month by the assistant director of nursing, and actions generated from audit finding were communicated to staff to improve practice. Nursing staff were up-to-date with medicines management and had evidence of attending refresher training.

**Judgment:**

Substantially 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:**

Resident's were supported to maintain their health and social care needs by a staff team with the relevant skills and experience. Feedback from residents and relatives was very positive. Some improvements were required with regard to care planning and the new record system. Also some aspects of the schedule 3 nursing narrative and language used in line with regulatory requirements. For example, as outlined in outcome 7 of this report positive behavioural care planning required specific review in terms of the indications for the use of any psychotropic medicines.

The inspectors reviewed a sample of resident's records. Evidence was seen that a pre-admission assessment was carried out before residents were offered a place in the centre. On admission a comprehensive assessment was carried out, and where residents had health or social care needs identified, care plans were developed. The care plans were found to person-centred in their approach, focusing on the impact of the resident's needs. Each plan detailed the resident's preferred approach to care and support, and clear instructions to guide staff in their practice. The plans were seen to be implemented effectively in practice by staff who knew the residents well. The care plans had recently been transferred to an electronic record-keeping system and staff were getting used to this new system. Inspectors noted that the daily nursing narrative was not reflective of, or referencing the care plan in place, and needed to be more specific. Audit and supports to staff in this ongoing transition were in place and the clinical nurse manager

informed inspectors he supported nursing staff.

Care plans were reviewed at least four monthly by the resident's allocated nurse. Records and care plans for residents with identified nutritional needs had been maintained since the last inspection had been maintained to a good standard. Evidence of the involvement of residents and families in completing any reviews was recorded. Records were signed by the residents and relatives detailed the discussion during the review meetings.

Where resident's had identified healthcare needs, records showed there were links with relevant medical professionals, or the wider multi-disciplinary team. Where resident's needs had changed records showed contact was made quickly with a general practitioner (GP). Where recommendations were made for treatment records showed it was provided, for example in relation to physiotherapy, or nutrition. The correspondence stored in residents' files showed that residents were in contact with hospitals and consultants for specific healthcare needs.

A range of evidence-based nursing tools were being used to assess residents' needs. This supported the nursing staff to monitor healthcare conditions, and reduce the risk of others developing. Where residents were identified as being at risk in relation to a particular healthcare need records showed action was taken to reduce that risk. For example where residents were identified as being at risk of falls, a holistic approach was taken to reviewing the resident's needs considering their medication, nutrition, physical ability, cognitive awareness and any aids or adaptations that may reduce the risk. The inspectors reviewed records of interventions following any slips, falls or near-misses and this included a medicines review and a mobility assessment by the physiotherapist and detailed balance and gait analysis recorded.

Where residents were temporarily absent from the centre, records showed that relevant information was sent with them. Also when resident's returned to the centre, for example from hospital, there was a clear summary of their needs and guidance on any interventions needed.

Residents told inspectors they enjoyed a range of activities in the centre, a programme of activities operated. Daily mass took place, music, games, movies, arts and crafts and bingo were organized by staff. Outings for residents were planned and operated regularly. Residents with cognitive difficulties could also access sensory therapy and one-to-one sessions and were individually assessed to ensure that suitable pastimes and hobbies could be maintained. Pet therapy is also a further available activity.

**Judgment:**

Substantially 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):**

No actions were required from the previous inspection.

**Findings:**

The centre was purpose built in the 1970s and is owned by the provider. The centre's design and layout met the needs of the current residents. It was spacious, clean, well maintained and met all the requirements of Schedule 6 of the regulations.

The centre consisted of four stories and one underground level. There were five residential units in total located on the first, second and third stories. In general the centre was spacious, visibly clean and well maintained. There were hand rails installed in all corridors and on both sides of all staircases in the centre. There were two lifts available between the floors. The flooring throughout the centre was safe and free from trip hazards.

The centre had 84 single rooms and one double room. All bed rooms were spacious and many residents had decorated them with their own belongings and furniture. All bedrooms had call bells installed and had sufficient storage for personal belongings. All bedrooms were en-suite.

The nursing home had plenty of communal space, each unit had a day room and dining area. There were also two large dining areas located on the ground floor. All communal rooms were decorated to a nice standard, had a homely atmosphere and had a call bell available for use by residents. The centre also had a shop, tea room, a large chapel, a large events hall and various other private communal areas. Residents could also access a large garden area at the rear of the centre. Some residents informed the inspectors that they regularly liked to visit the gardens to go for a walk. There were no restrictions to any residential or communal areas in the centre.

The centre had access to assistive equipment such as hoists, which records confirmed had been serviced within the last year. There was suitable storage for the assistive equipment.

**Judgment:**

Compliant

***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:**

The inspectors confirmed that any complaints that occurred in the centre were listened to and acted upon. Feedback was welcomed including comments, compliments and complaints and seen as a useful tool to improve service provision. The centre had written policies and procedures in place for managing complaints in the centre. The procedure for making complaints was found to be user-friendly and implemented fully. There was a guide explaining how to make a complaint available to residents and their representatives displayed in each unit. Details about supports in terms of social work and advocacy were in place. A suggestion box was also available in the centre.

The policy named a nominated person to manage complaints and a nominated person to oversee the management of complaints. An appeals person was also named in the event of dissatisfaction with the complaint. The inspectors requested to review any complaints records and informed that there had been none since the date of the last inspection. The person responsible for complaints was identified in the policy as the assistant director of nursing and she was clear about how she would complete an investigation.

Inspectors spoke to a number of residents and relatives and asked if they knew what the procedure was if they wished to make a complaint. All were aware of who they could speak to if they wished to make a complaint and all made complimentary comments towards the staff, and the person in charge stating that they felt staff and management would act upon any complaints or concerns they raised.

**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):**

No actions were required from the previous inspection.

**Findings:**

Residents were consulted with and participated in the running of the centre. Residents' rights were respected and their independence promoted. Some improvement was identified around the recording of residents' participation in activities.

There were residents' meetings held on a monthly basis in the centre. The meetings acted as a forum for the management to communicate any changes in the centre to the residents, and to facilitate residents to raise any issues or suggestions they had to the management. The last meeting was held on 22 July 2017. Issues discussed included the installation of new lighting, the re-decoration of some bedrooms, suggestions around the food and a suggestion that the date of the meetings being displayed in advance.

Residents informed the inspectors that they could choose to do what they wanted during the day. Residents stated that at meals they could order whatever they wanted if they didn't like the menu options and it was always facilitated. The inspectors observed that residents' independence was promoted. Residents were observed to leave the centre independently throughout the day. Residents could go to any area of the centre as there were no restrictions in place.

The inspectors reviewed a number of communication care plans for residents with communication difficulties. The care plans reviewed provided clear instruction on how to attend to the resident's communication needs. There were systems in place to assist residents to communicate.

There was an activities plan in place for the centre. The inspectors reviewed the activities plan and also reviewed the records kept of resident participation in activities. The records did not consistently accurately reflect the residents' participation in activities nor did they always outline if the resident did not wish to attend any activity. Although, inspectors found a variety of pastimes, individual and group activity. Some planned sessions of SONAS (a communication sensory therapy) were not being implemented in the small group to get the best outcomes in line with best practice guidance for this therapy. The provider undertook to review this at the time of feedback.

Residents' religious needs were met in the centre. The majority of residents in the centre were Roman Catholic. Daily Mass was held in the chapel in the centre. The mass could be live broadcast to televisions in each resident's room if they didn't wish to go to the chapel. Residents of other faiths were facilitated to attend services also, and inspectors were informed that residents also went out to services to practice their faith.

Voting in elections or referendums was facilitated in the centre. Residents could be registered to vote in the centre and a polling station would be set up there.

Visiting was encouraged, all visitors signed in at reception, and arrangements could be made at night after the doors were locked to have visitors. There was access to an independent advocacy service in the centre, contact details were displayed in the front reception of the centre. There was also electronic information boards located throughout the units which displayed general information about the centre.

All residents had access to a telephone in each of the five units. There was also access



to television, radio and newspapers.

**Judgment:**  
Compliant

***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):**

No actions were required from the previous inspection.

**Findings:**

The staffing levels and skill mix in the centre met the needs of the residents. There were suitable staff numbers and skill mix to meet the assessed needs of the residents. Staff were suitably supervised and recruitment procedures met the requirements of Schedule 2.

There was an actual and planned roster in the centre. During the day of the inspection there were four staff nurses rostered to work 07:30 to 20:00. There was a total of 22 healthcare assistants also working every day allocated to individual areas of the centre. Staff working on the units were supported by unit sisters. Nursing staff provided supervision of healthcare assistants. Nursing staff were observed to fully supervise mealtimes on the various units. Staff appraisals had commenced and senior managers completed the records of each appraisal.

The person in charge worked full-time in the centre six days a week. She was supported by the assistant director of nursing, a clinical nurse manager and the chief nursing officer who all worked four days, four days and five days a week respectively. Staff said they felt supported by the management in the centre and each one held a radio-pager whilst in the building to be contactable due to size and layout.

The inspectors reviewed a sample of six staff recruitment files. All files contained the requirements as per Schedule 2 of the regulations. The inspectors also reviewed the files of volunteers in the centre. Each volunteer had their role in the centre outlined. All volunteers and staff files reviewed in the centre had a copy of their Garda Síochána (police) vetting. The person in charge confirmed that all staff and volunteers in the centre had Garda vetting in place. All nurses had a copy of their registration pins with

the Nursing and Midwifery Board of Ireland.

Inspectors were informed that the recently appointed chief nursing officer will be responsible for co-ordinating training at the centre. Staff training records were in the process of being moved from one method of recording onto a training matrix, this was not yet completed. Staff spoken to were knowledgeable around their training and the policies and procedures in the centre. The inspectors reviewed the matrix for mandatory training. All staff were up-to-date with manual handling. However, as outlined in this report some staff were due for attendance for fire safety and safeguarding refresher training.

**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:***

Leone Ewings  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Action Plan

### Provider's response to inspection report<sup>1</sup>

Centre name:	Sacred Heart Residence
Centre ID:	OSV-0000157
Date of inspection:	27/07/2017
Date of response:	11/09/2017

### 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 01: Statement of Purpose

**Theme:**

Governance, Leadership and Management

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

The statement of purpose required updating with details of the revised organisational structure as notified to HIQA.

**1. Action Required:**

Under Regulation 03(2) you are required to: Review and revise the statement of purpose at intervals of not less than one year.

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

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

The Statement of Purpose has been updated with details of the revised organisational structure that is now in operation in the Home. This was forwarded to the authority on the 1st September 2017.

**Proposed Timescale:** 01/09/2017

**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:**

Records of resident participation in activities needed improvement. It was not clear if they accurately reflected resident participation.

Schedule 3 nursing narrative records required review to fully reflect the planned care and daily supports for each resident.

**2. 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:**

A review of the resident assessment and care planning process has taken place.

Nursing Staff are to receive direction and guidance on the assessment and person-centred care planning for individual residents. This will focus on developing accurate, individualised care plans, to include details of the resident's participation in activities.

Nursing staff will be receiving direction and guidance on maintaining personalised narrative notes and on reviewing the daily care records of the care staff.

Monitoring of this will be completed by frequent auditing of the resident's care records, findings of which will be fed back to relevant nursing staff.

**Proposed Timescale:** 30/11/2017

**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:**

Staff did not fully implement the restraint policy and required further training and guidance in the use of alternatives.

**3. Action Required:**

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

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

All members of the nursing staff are instructed to read the HIQA Guidance on Restraint Procedures and the Home's policy on the use of restraints.

In tandem with this, nursing staff will receive guidance on the use of alternatives to restraint and on the recording and reviewing of resident's care plans.

**Proposed Timescale:** 31/10/2017

### **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:**

All staff in the centre did not have up-to-date fire safety training.

**4. 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:**

A programme of training has been underway to ensure that all staff have up-to-date fire safety training.

It is expected that all staff will have completed fire training by the 28/9/2017.

A schedule of training for 2018 is being planned to maintain compliance with fire safety training into the future.

**Proposed Timescale:** 28/09/2017

### **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:**

The frequency and use of psychotropic PRN as required medicines was not consistently monitored and evaluated or in line with the centre's medication management policy.

**5. Action Required:**

Under Regulation 29(5) you are required to: Ensure that all medicinal products are

administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

All members of the nursing staff are instructed to read the HIQA Guidance on Restraint Procedures.

All residents who are prescribed PRN psychotropic medication will have person-centred care plans to detail the non-pharmacological positive behaviour approaches to be implemented in the event of reactive behaviours.

Nursing staff will receive guidance on the completion of narrative notes in the event of a psychotropic medication being used. This guidance will include; alternative approaches used and the evaluation of the use of the psychotropic medication.

The use of psychotropic medication and the compliance with the guidance to staff will be monitored on a monthly basis as part of the Home's KPI's.

Specific auditing will be conducted periodically to monitor all aspects of psychotropic medication usage.

**Proposed Timescale: 31/10/2017**

**Outcome 11: Health and Social Care Needs**

**Theme:**

Effective care and support

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

Care plans required specific review in terms of the indications for the use of any psychotropic medicines and positive behavioural supports in place.

**6. Action Required:**

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

Nursing staff will be given guidance on the preparation of care plans for residents who are prescribed psychotropic medications.

All residents who are prescribed PRN psychotropic medication will have person-centred care plans to detail the non-pharmacological positive behaviour approaches to be implemented in the event of reactive behaviours.

Nursing staff will receive guidance on the completion of narrative notes in the event of a psychotropic medication being used. This guidance will include; non-pharmacological approaches used and the evaluation of the use of the psychotropic medication.

**Proposed Timescale: 31/10/2017**