**Centre name:** Sacred Hearts Nursing Home  
**Centre ID:** OSV-0000156  
**Centre address:** Roslea Road, Clones, Monaghan.  
**Telephone number:** 047 51 069  
**Email address:** sacredhearts@arbourcaregroup.com  
**Type of centre:** A Nursing Home as per Health (Nursing Homes) Act 1990  
**Registered provider:** Varna Healthcare Services Limited  
**Provider Nominee:** Donal O'Gallagher  
**Lead inspector:** PJ Wynne  
**Support inspector(s):** Philip Daughen  
**Type of inspection:** Unannounced  
**Number of residents on the date of inspection:** 41  
**Number of vacancies on the date of inspection:** 0
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.
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

**The inspection took place over the following dates and times**
From: 13 January 2016 09:20  
To: 13 January 2016 18:30

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

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**Summary of findings from this inspection**
This report sets out the findings of an unannounced monitoring inspection. This inspection took place over one day. Notifications of incidents received since the last inspection were also considered and reviewed on this visit.

There were 41 residents in the centre at the time of this inspection. All residents except two were residing in the centre for continuing care. Many residents were noted to have a range of healthcare issues. The majority of residents had more than one medical condition. Each resident had a plan of care developed following an assessment of risk.

The registered centre is located within a building which was originally a convent. It was adapted in order to accommodate its current use as a residential centre for older people. The building is two storey and of traditional masonry construction. The internal walls and floor are a combination of masonry as well as stud partition walls. The roof is pitched and runs along the length of the extension. It is located on a site providing off street car parking and green areas around the building. There are also numerous single storey buildings located on the site, mostly used for storage. The
bedrooms and care environment was adequately lit, heated and ventilated. There was choice of a variety of food available to residents at each meal time.

The governance arrangements for the management of the centre have changed recently. The Authority received a notification of a change of person in charge in November 2015. The nominated person to fulfill the role of the person in charge meets the requirements of the Regulations in terms of qualifications and experience.

A total of nine Outcomes were inspected. The inspector judged two Outcomes as moderately non compliant. These include Health and Social Care Needs and Safe and Suitable Premises. Three Outcomes were judged as compliant with the Regulations and a further four as substantially in compliance with the Regulations.

The areas of moderate non compliance primarily related to;

Aspects of the premises did not fully meet the needs of the residents. While the centre was managed in a way that minimised the potential impact, a number of the single bedrooms were not able to fully meet the current or prospective needs of all residents due to either their size or accessibility. The width of some corridors posed a restriction to easy movement of people at times within the centre.

The end of life care policy and procedures require review. A system was not developed to ensure residents with a (DNR) status in place have the decision regularly reviewed to uphold the validity of the clinical judgement on an ongoing basis. Medical notes evidenced nominated medical teams did not visit the centre regularly to review medication and reissue each resident’s prescription.

The action plan at the end of this report identifies these and other areas where improvements must be made to meet 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 Quality Standards for Residential Care Settings for Older People in Ireland.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

**Outcome 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:**
It was found that the statement of purpose accurately described the aims, objectives and ethos of the centre and the service that was provided. 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. The statement of purpose is kept under review by the provider and had been updated in October 2015 to reflect changes in the management organisational structure.

**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):**

**Findings:**
The Authority received a notification of a change of person in charge in November 2015. The person in charge is a registered nurse and is noted on the roster as working in the post-full-time.
The nominated person to fulfil the role of the person in charge has more than three years experience of nursing older persons within the last six years as required by the Regulations.

He has attended mandatory training required by the Regulations. The notified person in charge is currently undertaking a Further Education and Training Awards Council (FETAC) Level 6 course in Leadership and Management in Nursing Homes.

The person in charge facilitated the inspection well and provided all information requested by the inspection team.

**Judgment:**
Compliant

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**Outcome 05: Documentation to be kept at a designated centre**
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Written operational policies, which were centre specific, were in place to inform practice and provide guidance to staff.

A sample of five staff files were examined to assess the documentation available, in respect of persons employed. All the information required by Schedule 2 of the Regulations was available in the staff files reviewed.

A directory of residents was maintained update. The inspector noted the details of the most recent admission and most recent death were recorded in the directory.

Records were stored securely and easily retrievable.

**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):**

**Findings:**
There was a policy on adult protection to guide management and staff. Access and egress to the centre was monitored. There was a visitors log in place.

Garda Síochána vetting had been applied for all staff members. This was evidenced by a review of returned Garda Siochana vetting forms examined by the inspector in the files of staff recruited.

Staff spoken with were able to inform the inspector of what constituted abuse and of their duty to report any suspected or alleged instances of abuse. Staff when spoken with identified a senior manager as the person to whom they would report a suspected concern. The inspector viewed records confirming staff had up to date refresher training in relation to the detection and prevention of and responses to abuse.

Training in the communication of residents’ with dementia was completed by 26 staff. However, all staff involved in residents care did not have up to date knowledge and skills appropriate to their role, to respond to and manage behaviour that is challenging.

There was a policy on restraint management (the use of bedrails and lap belts) in place. There was a risk assessment completed prior to the use of the bedrails. Assessments were regularly revised. Signed consent was obtained by the resident or their representative and the nominated medical team member. Restraint risk assessments were revised at routine intervals and supported with a plan of care.

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

Findings:
On this inspection, inspectors noted that the centre was provided with many of the facilities necessary to provide an adequate level of fire safety for residents. The centre was provided with a fire detection and alarm system for detecting and raising the alarm in the event of a fire. For the purposes of fire detection, the building was divided into eight zones. The zone in which the fire was detected was displayed on the alarm panel in the stair hallway inside the front door. There was also a secondary alarm panel further down the building within an electrical services room. The centre was provided with emergency lighting as well as emergency exit signage. The centre was also provided with fire extinguishers.

The inspectors noted that the building was subdivided generally with fire resistant construction to contain fire and prevent the movement of fire and smoke within the building in the event of a fire. To that end, the majority of doors within the centre were fire resistant doors of varying types and were provided in order to contain a fire should one occur within the room in which it started and prevent the movement of fire and smoke through the building. These doors were provided with the necessary fire and smoke seals as well as self closing devices necessary for them to fulfil their function of containing a fire. Closer examination of the doors by inspectors indicated that a number of the doors required adjustment in order for them to function effectively. A number of doors were identified as requiring adjustment to the position they sat in the frame so that they closed fully and the gaps between the door leaves and the frame were minimised to prevent smoke passing the door in the event of a fire. Inspectors found a number of doors that required adjustment to the self closing device in order to ensure they closed fully when required and two doors where the self closing device was not functioning. These issues were highlighted to the maintenance staff on inspection and who commenced repairs as required during the inspection. Many doors were fitted with hold open devices to ensure the door remains open but close upon activation of the fire detection alarm. These were demonstrated as functioning during a test conducted by maintenance staff while inspectors were present.

The escape routes from the building were observed as being free from obstruction on inspection. Storage of equipment and materials including materials that can burn was noted as being within suitable rooms dedicated for the purpose in the main. Rooms containing potential ignition sources such as electrical switch rooms were identified as being free from materials that can burn. Isolated instances of storage of materials that can burn within an escape route were noted. In one case, storage within a lobby outside a bedroom was observed, although it was not stored in a manner that was obstructing the escape route. Another instance of storage of paperwork and other materials that can burn was identified in a room annotated on drawings as an office that was not separated from a bedroom corridor with a fire resistant door.

With respect to fire safety management, there were arrangements in place for appropriate maintenance of fire safety systems such as the fire detection and alarm system. Inspectors viewed records of checks being carried out both daily and weekly in
order to ensure all fire safety equipment was present and functioning. Inspectors were present for the weekly bell test of the fire alarm where correct operation of the fire detection and alarm system was checked. Inspectors viewed documentation demonstrating on-going engagement with the fire authority where modifications to the building, including to the fire resistant doors, and to fire precautions in place generally were agreed in order to improve the level of fire safety provided with the building.

The electrical system included an electrical switch room which was noted as being free from materials that can burn. Inspectors also noted that suitable arrangements for the periodic inspection of the electrical system and appliances within the building were in the process of being agreed with the fire authority. Inspectors also noted that hoist equipment and appropriate beds had been provided to meet the needs of the residents. Inspectors viewed documentation demonstrating that this equipment was serviced as necessary.

The fire and evacuation procedures were displayed adjacent to the alarm panel on the ground floor and within the lift lobby on the first floor. As previously mentioned, the fire alarm system divided the centre in to eight zones. The evacuation procedure, which was one of phased evacuation of the building, made reference to the evacuation of residents from the zone in which the fire was detected to adjacent zones. However, because the fire resistant construction dividing the building in to compartments within the building did not align correctly with the boundaries between the zones in all cases, the possibility existed in a limited number of scenarios that residents and other building occupants would not be evacuated to an area sufficiently remote from the fire in the event one should occur when the procedure was being followed.

Inspectors found that the needs of the residents had been assessed in the event of an evacuation of the centre. Their needs were recorded and were reviewed on a daily basis. The residents were provided with appropriate evacuation aids, informed by the assessment, throughout the centre to ensure they could be evacuated in a timely fashion in the event of a fire.

The records present relating to training of staff examined by inspectors indicated that all staff had received fire safety training. Any staff spoken to by inspectors appeared to have the requisite knowledge with respect to same. Inspectors also saw records that indicated that the training covered the use of, and practice with, evacuation aids which is indicative of good practice. Inspectors were provided with fire drill records indicating regular drills were taking place and that real life scenarios such as a night time evacuation were being simulated with appropriate staff levels which was indicative of good fire safety practice.

It was found that there was a safety statement in place and a risk register where hazards within the centre were identified and risks were assessed on a systematic basis within the centre. There were records of regular health and safety audits being carried out within the centre. There was evidence that good health and safety practice was being followed generally in the centre as observed by the inspector, with the exception of one of the external areas, which will be discussed under Outcome 12: Safe and Suitable Premises.
**Judgment:**  
Substantially Compliant

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**Outcome 09: Medication Management**  
*Each resident is protected by the designated centre’s policies and procedures for medication management.*

**Theme:**  
Safe care and support

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

**Findings:**  
The inspector reviewed the medication management policy and noted that it included the procedure for prescribing, administering, recording, safekeeping and disposal of unused or out of date medications.

Each resident’s medication was dispensed from blister packs. These were delivered to the centre on a monthly basis. The inspector reviewed a sample of drugs charts. The prescription sheets reviewed distinguished between PRN (as needed), regular and special course medication.

The majority of prescriptions sheets reviewed were clear and legible. However, in one of the sample of prescriptions reviewed, drugs were being administered from two separate prescription sheets, one dated 11 November 2015. The second was a faxed copy dated, 17 December 2015. This prescription was not clear. Nebuliser medication was noted to have a line marked through indicating the medication was discontinued. However, it was not signed by the medical prescriber as discontinued in the assigned column on the prescription sheet. The nebuliser medication continued to be administered from the prescription dated 11 November 2015. In one other kardex a medication was marked as discontinued. However, the medication was not signed as discontinued by the medical prescriber.

The medication administration sheets viewed were signed by the nurse following administration of medication to the resident. These recorded the name of the drugs and times of administration. The drugs were administered within the prescribed time frames. There was space to record when a medication was refused on the administration sheet.

Medications that required strict control measures were kept in a secure cabinet which was double locked in keeping with the Misuse of Drugs (Safe Custody) Regulations. Nurses kept a register of controlled drugs. Controlled drugs were checked by two nurses at the change of each shift.

There were six residents on controlled drugs at the time of this inspection. The inspector checked the records of the balance of stock of two resident’s medication and found them to be correct.
The temperature of the fridge containing drugs requiring refrigeration was monitored.

**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):**

**Findings:**
There were 41 residents in the centre at the time of this inspection. All residents, except two, were residing in the centre for continuing care. The remaining two residents were admitted for short term care. There were ten residents with maximum care needs. Five residents were assessed as highly dependent and 15 with medium dependency care needs. Eleven residents were considered low dependency. Many residents were noted to have a range of healthcare issues and the majority had more than one medical condition.

A comprehensive assessment of the health and personal needs of residents’ was completed on admission. Risk assessments were reviewed at periodic intervals. Validated assessment tools were used to evaluate residents’ progress and to assess levels of risk for deterioration, for example vulnerability to falls, dependency levels, nutritional care, the risk of developing pressure sores and continence needs.

In one of the sample of care plans reviewed risk assessments were not reviewed within the four monthly intervals specified in the Regulations. The resident had hospital admissions and was unwell at the time of inspection. While the end of life care plan was revised risk assessments were not reviewed following readmission to the centre from hospital.

Each resident had a plan of care developed following an assessment of risk in the sample examined. The layout of the care plans documentation identified the problem, the goal of care and the interventions required. There was evidence of consultation with residents or their representative in all care plans reviewed.

There was evidence of medical reviews shortly after admission and when a resident became unwell. However, medical notes evidenced the nominated medical team did not
visit the centre regularly to review medication and reissue each resident’s prescription. The group operations manager and current person in charge confirmed to the inspection team they had identified this issue. Inspectors were informed that a meeting had occurred with the relevant medical team to discuss and resolve the matter.

There was one resident with a wound being dressed at the time of this inspection. A notification was submitted to the Authority as required by the Regulations on 4th December 2015 to report the incident. Nursing staff had made a referral to seek expert advice. While records evidenced some improvement initially the wound deteriorated prior to this inspection. The person in charge had made a referral to another external healthcare professional and followed up by telephone to seek guidance in relation to the initial dressing regime.

There was ongoing monitoring of residents nutritional and hydration needs with each resident’s weight checked monthly. Staff monitored the food and fluid intake of residents identified with a nutritional risk. There was evidence of review by a dietician for residents identified as at risk.

There was an end-of-life care policy to guide staff. In the sample of care plans reviewed each resident had an end of life care plan. However, the end of life care policy and procedures require review. One end of life care plan identified a resident was not for cardio pulmonary resuscitation. However, a multi disciplinary approach was not undertaken. There was no documented medical opinion in the care file to outline this was the consensus decision.

There were three residents with an active do not resuscitate (DNR) status following discharge from hospital. However, a system was not developed to ensure residents with a (DNR) status in place have the (DNR) status regularly reviewed to assess the validity of the clinical judgement on an ongoing basis. The group operations manager concurred with these finding when discussed by the inspectors and confirmed to the inspection team the end of life care policy would be reviewed.

**Judgment:**
Non Compliant - Moderate

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**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

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**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
Inspectors found that the centre was adequately lit, heated and ventilated. The centre was heated by an oil fired central heating system and there were records relating to maintenance of same. Inspectors noted that the water when checked at a number of hot taps was thermostatically controlled at an appropriate temperature in order to prevent scalding. The laundry and cooking facilities were fuelled with liquefied petroleum gas from a tank on the grounds. The provider also informed inspectors that an automatic shut off for the gas was provided. There was also evidence of good maintenance practice relating to the kitchen and laundry equipment. Inspectors noted that the kitchen exhaust duct work had recently been checked and cleaned by a competent person and also the laundry equipment was kept free of lint accumulation through daily checks and cleaning.

The residents were accommodated in either single or twin bedrooms. Where they were accommodated in twin bedrooms, the rooms were provided with screening by way of curtains for privacy. The bedrooms were provided with wash hand basins. Toilet facilities as well as bath and shower facilities were provided communally throughout the centre with the exception of one bedroom which was provided with an en suite room. On the previous inspection, it was found that some areas of the centre were not appropriately sized to meet the needs of the residents, particularly if the resident concerned was high or maximum dependency. On this inspection, it was found that while management arrangements were implemented to minimise the impact of the limited size of some areas of the centre on the residents, this did not fully address the impact on the residents.

Inspectors found that there were seven single bedrooms provided on the first floor, where due to their size, approximately eight square meters in floor area, they would be unable to effectively meet the needs of residents with high mobility needs such as the need to use a hoist for getting in and out of bed. The inspectors noted that the centre have taken steps to address this through a pre admission assessment for occupants of these rooms in order to make sure the room is adequately sized to meet the needs of individual residents before they occupy these rooms. While managing the bedrooms this way does address the issues with the size of these bedrooms, inspectors noted that there was still the possibility that any individual resident admitted to these rooms may have to be transferred back out of these rooms should their mobility needs increase post admission.

On the date of the inspection, one occupant of these rooms required the use of a hoist following a recent change in their mobility needs. There were also two single bedrooms on first floor which were accessed from the rest of the centre by way of a flight of steps. These bedrooms were noted by inspectors as identified as only being for occupation by independently mobile residents. This is a condition applied to the centre's registration at the time of application to renew registration. It was found on inspection that one of the two residents was independently mobile and that the other, while not mobile, had occupied the rooms for a number of years previously and accordingly had expressed her wishes to remain in the room. It was agreed that condition eight would apply to any
future new admission to this bedroom.

The residents were provided with accessible outdoor space for recreation. There were two main areas, one of which was provided with a secure perimeter for the safety of residents with dementia. It was observed that the surface of the tarmacadam area at the front of the centre used for car parking and the primary access to the centre was breaking up and required repair or renewal to ensure it did not represent a trip hazard, particularly to people with mobility aids using the area to access the centre.

Access throughout the centre was provided primarily by way of a corridor that ran down the building on ground and first floor. This corridor was measured as approximately 950 - 1050 millimetres wide in various locations, excluding the single handrail provided along most of its length. For this reason, two people travelling in opposite directions were not able to pass each other easily. This was observed on inspection when one or both of the people was a staff member with equipment or a trolley, or when one or both of the people was a resident with a mobility aid such as a walking frame. It was observed by inspectors as being frequently necessary for one party to step back along the corridor or in to a room off of the corridor in order to allow the other to pass by.

**Judgment:**
Non Compliant - Moderate

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**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

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

**Findings:**

There are two nurses rostered from 8:00 am till 13:00 pm and one nurse for the remainder of the day to meet the clinical care needs of 41 residents. The person in charge is rostered five days each week from 9:00am to 17:00 hrs to oversee the management and administration of clinical and governance matters.

There are 6 care assistants rostered from 08:00am till 13:00 hrs to meet the personal and physical care needs of 41 residents. In the afternoon, from 1:00 pm, the care assistant levels decrease to four care assistants till 9:00pm. From 9:00 pm there are two
care assistants and one nurse rostered for night duty to meet the care needs of 41 residents accommodated on two separate floors of the building. The night duty nurse after handover report from day staff is required to complete the night time medication round. To administer all medications the round can take two hours to safely complete the inspector was informed by nursing staff.

There are catering, cleaning, an activity coordinator and maintenance staff employed. The inspector noted that the planned staff rota matched the staffing levels on duty.

The inspector found a continuous review of the number and skill mix of staff to ensure appropriate care can be delivered having regard to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre is required for the afternoon and evening time was required.

There was a training matrix available which conveyed that staff had access to ongoing mandatory training as required by the Regulations.

**Judgment:**
Substantially Compliant

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**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:**

PJ Wynne
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 report

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<td>OSV-0000156</td>
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<td>Date of response:</td>
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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 Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

All staff involved in residents care did not have up to date knowledge and skills appropriate to their role, to respond to and manage behaviour that is challenging.

1. 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

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

Please state the actions you have taken or are planning to take:
The staff of the nursing home have access to a variety of external formal courses that supplement the in-house training and supervision provided. The home has a robust and centre specific policy on Behaviours that Challenge which is implemented in full. Records show that 34 staff members have read the Policy, 22 staff have undergone formal external Communication in Dementia, and 2 RGN’s and 8 other staff grades have completed Dementia Care.
Outcomes show that our reaction to any behaviour that challenges is timely and appropriate.
A review of the three training sources will be conducted to identify any relevant staff members that have not completed some form of training in Behaviour that Challenge and follow up training to capture all staff will be completed.

Proposed Timescale: 30/04/2016

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The arrangements in place for the maintenance of the means of escape were not adequate in the following respects:

A number of fire resistant doors were identified as not being maintained in a condition that enabled them to effectively fulfil their function of containing fire and smoke.

Materials that can burn were stored in areas not separated from escape routes with construction capable of containing fire and smoke.

2. Action Required:
Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

Please state the actions you have taken or are planning to take:
Cross corridor fire doors separating 30 minute fire compartments and escape routes are checked weekly. Bedroom and other fire doors are checked monthly.
Some doors were found to not close fully on the door closers when release to do so and 2 door closers were not working. These were all replaced, adjusted and checked by our contractor on Friday 15/01/2016.

On the day of the inspection there was a box of items placed incorrectly in the lobby area outside 2 bedrooms. This was immediately removed. The only items stored in these 2 lobby areas are items that do not readily combust and that are required for the delivery of service to and the movement of residents such as hoists and wheelchairs.
The building is fully certified to a L1 standard Fire Detection and Alarm system thereby ensuring that should a fire event occur it would be immediately identified thereby minimising any risk to residents, visitors and staff. The building is fully certified by a competent person as required by legislation.

**Proposed Timescale:** 15/01/2016

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The arrangements in place for evacuation of residents required review as the fire resistant construction within the centre did not align with the zones in place for the purposes of the evacuation procedure.

**3. Action Required:**
Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

**Please state the actions you have taken or are planning to take:**
Three rooms were identified as being listed in areas that did not align with the Fire Detection and Alarm Zones. This was due to on-going improvement works that altered the use of the rooms.
Our Fire Alarm contractor has altered the zoning of these rooms. Now all rooms within each of the 8 Fire Alarm Zones are aligned and contained within the zones.

**Proposed Timescale:** 10/02/2016

**Outcome 09: Medication Management**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
In one of the sample of prescriptions reviewed, drugs were being administered from two separate prescription sheets. This prescription was not clear. Nebuliser medication was noted to have a line marked through indicating the medication was discontinued. In one other kardex a medication was marked as discontinued. However, the medication was not signed as discontinued by the medical prescriber.

**4. 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:
In November 2015 we identified a need to improve the signing of altered prescriptions and Kardex Medication management sheets. We met with the team in the local GP’s Surgery and plans to improve this were developed. There has been a vast improvement over the past 2 months but this matter is still under review. We will conduct a detailed review by 11/03/2016 and put improvement plans in place for any further errors identified.

Proposed Timescale: 11/03 2016 and 30/04/2016 if action plan is required.

Proposed Timescale: 30/04/2016

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:
In one of the sample of care plans reviewed risk assessments were not reviewed within the four monthly intervals specified in the Regulations.

5. Action Required:
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident’s family.

Please state the actions you have taken or are planning to take:
This identified error was corrected on the day of the inspection, 13/01/2016

Proposed Timescale: 14/01/2016

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A system was not developed to ensure residents with a (DNR) status in place have the (DNR) status regularly reviewed to assess the validity of the clinical judgement on an ongoing basis.

6. Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).
Please state the actions you have taken or are planning to take:
We will review our policy on DNR following identification of current best practice and discussions with the residents GP’s. Any changes will be implemented immediately following this review.

**Proposed Timescale:** 30/04/2016

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Medical notes evidenced the nominated medical team did not visit the centre regularly to review medication and reissue each resident’s prescription.

**7. Action Required:**
Under Regulation 06(2)(a) you are required to: Make available to a resident a medical practitioner chosen by or acceptable to that resident.

Please state the actions you have taken or are planning to take:
As identified above we have identified areas where the GP interaction with the nursing home and the residents can be improved and we are working to ensure that this occurs.
Currently the GP signs off on the residents prescriptions as issued and the residents Kardex Medication management sheets monthly.
Our pharmacist attends on site to review the medications quarterly.
A further detailed review of processes and procedures will be conducted by 11/03/2016 and if an action plan is required it will be developed and implemented following further discussion with the GP’s by 30/04/2016.

Proposed Timescale: 11/03/2016 and 30/04 2016.

**Proposed Timescale:** 30/04/2016

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There were was one resident with a wound being dressed at the time of this inspection but specialist advise to outline the type and frequency of dressing had not being obtained within a suitable time frame.

**8. Action Required:**
Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service
Please state the actions you have taken or are planning to take:
On 1/12/2016 the wound was discovered and a dressing immediately applied by the team in the Sacred Hearts Nursing Home. The GP attended the next day and advised transfer to Cavan General Hospital for specialist intervention. The resident returned to the nursing home that evening at 10.30pm with no change to the dressing regime commenced by the team at the nursing home.
The Person in Charge made a referral for guidance and review by an external healthcare professional and followed up by telephone on several occasions.
We continued to follow the wound management regime with excellent outcomes up until January 2016 when a deterioration was evident.
On 8/01/2016 a referral to a private external healthcare professional was made and she attended on 14/01/2016. A change to the dressing regime was recommended and further contact with the HSE was made to arrange the introduction of the recommended regime. Approval of the regime was received on 17/02/16, with the dressings received on 19/02/16. An immediate improvement of the wound is evident.

We will continue to seek professional specialist interventions when required in the best interest of the health of the residents.

Proposed Timescale: 19/02/2016

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One end of life care plan identified a resident was not for cardio pulmonary resuscitation. However, a multi disciplinary approach was not undertaken. There was no documented medical opinion in the care file to outline this was the consensus decision.

9. Action Required:
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Chnáimhseachais.

Please state the actions you have taken or are planning to take:
The entry in the residents care plan was as a result of consensus between the nursing home management, the resident and the residents family.
We will request that the GP offers his medical opinion on same and the necessary entries in the medical notes and care plan will follow.

Proposed Timescale: 31/03/2016
Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The premises did not fully meet the needs of the residents in the following respects:

While the centre was managed in a way that minimised the potential impact of same, a number of the single bedrooms provided were not able to fully meet the current or future needs of all residents due to either their size or accessibility.

The width of some corridors posed a restriction to easy movement of people at times within the centre.

The surface of the external area was observed as beginning to break up and required repair or renewal to ensure it did not pose a trip hazard to people accessing the centre, particularly those with mobility aids.

10. 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:
We have single bedrooms that are below the recommended size requirements. All residents proposed for these rooms are assessed before admission and then re-assessed on an on-going basis or as required when their condition changes to ensure that we can continue to meet their assessed needs in these bedrooms.

Our corridors are narrow but the nursing home is in existence since 1974 and we manage the corridor width without difficulty. The management of the narrow corridors has been previously recognised by HIQA inspectors during previous inspections. The corridor widths cannot be altered.

The surface of the car park has started to deteriorate. We continually monitor this and fill any areas of deterioration to minimise any risks to residents, visitors and staff. Following the inspection some minor defects were identified and filled immediately.

Proposed Timescale: 22/01/2016

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector found that a further review of the number and skill mix of staff to ensure appropriate care can be delivered having regard to the needs of the residents assessed in accordance with Regulation 5 and the size and layout of the designated centre is required for the late afternoon and evening time was required.

11. **Action Required:**
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**
We continuously review our staffing levels through a detailed assessment of each resident and their needs. We use daily cover sheets that identify the staffing levels for each one hour period throughout the 24 hour day.
A further review of staffing levels will be completed at the next monthly management meeting on 24/02/2016

**Proposed Timescale:** 24/02/2016