

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Sacred Heart Nursing Home
Centre ID:	OSV-0005557
Centre address:	Crosspatrick, Johnstown, Kilkenny.
Telephone number:	056 883 1318
Email address:	sacredheartnursinghome@gmail.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Sacred Heart Nursing Home Limited
Lead inspector:	Vincent Kearns
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	33
Number of vacancies on the date of inspection:	15

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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 monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
04 April 2018 08:30	04 April 2018 18:00
05 April 2018 07:30	05 April 2018 15:00

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Compliance demonstrated	Substantially Compliant
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Compliant
Outcome 04: Complaints procedures	Compliance demonstrated	Compliant
Outcome 05: Suitable Staffing	Compliance demonstrated	Compliant
Outcome 06: Safe and Suitable Premises	Compliance demonstrated	Non Compliant - Moderate
Outcome 07: Health and Safety and Risk Management		Non Compliant - Moderate
Outcome 08: Governance and Management		Compliant

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care. As part of the thematic inspection process, providers were invited to attend information seminars given by the Authority. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process. Prior to this inspection, the person in charge completed the provider self-assessment and compared the service with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and

the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection focused on the care of residents with a dementia in the centre. Care practices were observed and interactions between staff and residents who had dementia were rated using a validated observation tool. Documentation such as care plans, medical records and staff training records were examined. The inspector also considered progress towards compliance following the previous inspection carried out in November 2017. The inspector noted that there had been significant improvements in the centre with all the actions from the previous inspection had been satisfactorily completed.

The inspector met with residents, staff members, the assistant directors of nursing, the operations manager, the person in charge and provider representative. The inspector tracked the journey of a number of residents with dementia within the service, observed care practices and interactions between staff and residents who had dementia using a validated observation tool. The inspector also reviewed documentation including staff files, relevant policies and the self assessment questionnaire, submitted prior to inspection.

The centre did not have a separate unit for people with dementia. At the time of inspection there were 11 residents living in the centre with a formal diagnosis of dementia. With a further seven residents suspected of having dementia. The inspector observed that a small number of residents required a considerable level of assistance and monitoring due to the complexity of their individual needs. Overall, the inspector found the person in charge, the management and staff team were committed to providing a good quality service for residents with dementia. The inspector found that residents' overall healthcare needs were met and they had access to appropriate medical and allied healthcare services. The quality of residents' lives was enhanced by the provision of a choice of interesting things for them to do during the day and an ethos of respect and dignity for residents was evident. There was an activities coordinator and all staff fulfilled a role in meeting the social needs of residents and staff connected with residents as individuals. The inspector found that residents appeared to be well cared for and residents gave positive feedback regarding all aspects of life in the centre. The person in charge and provider representative had carried out on-going improvements to create a comfortable homely environment. The person in charge had submitted a completed self-assessment tool on dementia care to HIQA with relevant policies and procedures prior to the inspection. The person in charge had assessed the compliance level of the centre through the self assessment tool and the findings and judgements of the inspector generally concurred with the person in charge's judgements. From the eight outcomes reviewed during this inspection, five outcomes were compliant. Health and social care needs was deemed to be substantially compliant. Moderate non-compliances were found for health and safety and risk management and safe and suitable premises. These non-compliances were discussed throughout the report and the action plan at the end of the report identified where improvements were needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National 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 Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

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

Findings:

This outcome sets out the inspection findings relating to healthcare, assessments, care planning and medication management. The social care of residents with dementia was discussed in outcome 3.

Since the previous inspection there had been a number of improvements in the systems for the provision of nursing care including a review of the admissions policy to ensure all potential residents needs could be suitably met, taking into consideration the residents already living within the centre. In relation to admissions to any shared bedroom, the person in charge outlined how a shared room risk assessment was completed prior to any such admission and help inform the suitability of such admission. A care plan audit was most recently completed in March 2018 and the findings from this review informed discussions with staff and management team meetings. The inspector noted that following these meetings corrective actions were taken including regular care audits and changes to the care planning documentation. The person in charge outlined how the improved skill mix and protected managerial support had also enhanced clinical governance and oversight in the centre. For example, all residents with dementia and/or their representatives had completed questionnaires that informed staff as to their choices and preferences for end of life care. There had been an audit of meals and meal times which resulted with the introduction of a breakfast club that was very popular with residents including some residents with dementia.

There were a total of 33 residents in the centre on the day of this inspection. Residents had been assessed as having the following dependency needs: seven residents had low dependency needs, ten residents had medium dependency needs, eight residents had high dependency needs with a further eight residents assessed as having maximum dependency needs. Eleven residents had a formal diagnosis of dementia with a further seven residents suspected of having dementia. The inspector found that each resident's wellbeing and welfare was maintained by a good standard of nursing care and appropriate medical and allied health care. There were processes in place to ensure that when residents were admitted, transferred or discharged to and from the centre,

relevant and appropriate information about their care and treatment was available and maintained, and shared between providers and services.

A selection of residents' files and care plans were reviewed and the inspector focused on the experience of residents with dementia on this inspection. The inspector tracked the journey of four residents with dementia and also reviewed specific aspects of care such as nutrition, wound care and end of life care in relation to other residents. There was a documented

comprehensive assessment of all activities of daily living, including communication, personal hygiene, continence, eating and drinking, mobility, rest and sleep. There was evidence of a range of assessment tools being used to assess and monitor issues such as falls, pain management, mobilisation and risk of pressure ulcer development. There were a number of residents who had wounds. However, each had suitable wound care plans completed and pressure relieving mattresses when appropriate, were provided. Residents were weighed on a monthly basis or more frequently, if required. There was evidence of a pre-assessment undertaken prior to admission for residents and some of the residents had been transferred to this centre following admission in an acute hospital services. Each resident had a care plan developed within 48 hours of their admission based on their assessed needs. There was documented evidence that residents and their families, where appropriate, were involved in the care planning process, including for example end of life care plans which reflected the wishes of residents with dementia.

On the previous inspection improvements were required for some care plans and on this inspection, the inspector noted from a sample of care plans reviewed that each residents' care plan and care needs were contemporaneously recorded and reflected changes in their circumstances and identified health and social care needs. Overall, there were adequate systems in place for the assessment, planning, implementation and review of healthcare needs. The assistant director of nursing informed the inspector that she and the person in charge monitored residents care plans, as appropriate. From a review of a sample of residents care plans, a daily nursing record of each resident's health, condition and treatment given was maintained and these records seen were adequate and informative. Each resident's vital signs were recorded regularly with action taken in response to any variations. Overall, the majority of assessments and care plans were reviewed four-monthly or more frequently as required. However, the inspector noted in one reviewed care plan not all assessments had been recorded as being reviewed within four-months, as required by regulation.

Each resident's wishes for end of life care was elicited and used to inform a plan of care to meet their holistic needs. The person in charge confirmed that residents had access to single rooms for end of life care and families were facilitated to stay overnight if they wished to do so. Staff were supported by the community palliative care team for symptom relief and to provide end of life care. Audits of end of life care plans had been completed and the inspector noted from the sample of care plans reviewed that all accurately recorded the resuscitation status of each resident. Staff spoken to by the inspector were knowledgeable about residents' wishes and status.

The person in charge outlined that since the previous inspection, there was a new

method of auditing resident's satisfaction with nutrition and food services which included a new audit tool that was dementia friendly. For example, this audit tool contained pictures to assist residents' understanding and comprehension. There was timely access to dietetic services and specialist advice was incorporated into care plans. Nurses' narrative notes were linked to the care plans. Residents had access to medical services delivered by visiting general practitioners (GPs) and out-of-hours medical cover was provided. Residents had access to psychiatry of later life services and a range of other services were available on referral including speech and language therapy (SALT), chiropody, physiotherapy and optical services. There was regular on-going support provided by the visiting community psychiatric nurse. Nursing care plans had been updated to reflect the recommendations of various members of the multidisciplinary team.

Clinical input from the speech and language therapy services was evident and residents with dementia received adequate hydration. Staff for example, were observed suitably supporting residents with dementia in relation to maintaining their hydration. All residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis and more frequently if evidence of unintentional weight loss was observed. Residents were provided with a choice of nutritious meals at mealtimes and all residents spoken to were complimentary about the food provided. The inspector spoke to the chef and noted that there was an effective system of communication between nursing and catering staff to support residents with special dietary requirements. Mealtimes was observed by the inspector to be a social occasion. Staff were observed sitting with residents while providing encouragement or assistance with their meal. Nursing staff told the inspector that if there was a change in a resident's weight, nursing staff would reassess the resident, inform the GP and referrals would be made to the dietician and speech and language therapy services. Files reviewed by the inspector confirmed this to be the case. Nutritional supplements were administered as prescribed. Staff including catering staff, were aware of residents who required specialised diets or modified diets and were knowledgeable regarding the recommendations of the dietician and SALT.

Overall the inspector found evidence of safe medication management practices. Evidence was available that regular medication reviews were carried out. Medications that required strict control measures under the Misuse of Drugs Act's (MDAs) were carefully managed and kept in a secure cabinet in line with professional guidelines. Nurses kept a register of MDAs and the inspector checked a sample of balances and found them to be correct. There was a list of nurses signatures maintained in relation to the administration of medications in the centre. However, procedures for checking stocks when shifts change were not consistently done in line with the centres policy. As the inspector noted that one signature was absent from one stock balance record in relation to one stock balance of MDA medications. There was a small quantity of stock emergency medications stored in the centre and there were procedures for the handling and disposal of unused and out-of-date medicines. There was a record kept of this stock including the expiry dates for each medication. However, some improvement was required in the monitoring of this stock as the inspector noted that the expiry date of one medication had just expired at the end of March 2018.

Judgment:

Substantially Compliant

Outcome 02: Safeguarding and Safety**Theme:**

Safe care and support

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

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

Findings:

All staff had received training on identifying and responding to elder abuse. There was a centre specific policy in place signed and dated by the person in charge in October 2017 and copies of the national Health Service Executive (HSE) policy on safeguarding vulnerable persons at risk of abuse was also available to staff. The person in charge and staff who spoke with the inspector displayed sufficient knowledge of the different forms of elder abuse and all were clear on reporting procedures. For example, staff interviewed were familiar with the policy and knew what to do in the event of an allegation, suspicion or disclosure of abuse, including who to report incidents to. Residents spoken to also confirmed that they felt safe living in the centre. The operations manager confirmed that all staff had Garda clearance and this was found to be the case when a sample of staff files was examined.

Since the previous inspection there had been improvements in the measures the provider representative and the person in charge had in place to protect residents from being harmed or abused. Residents spoken with reported positively on the experience of living at the centre stating that they were comfortable and felt safe and secure. It was clear to the inspector that residents including residents with dementia, were treated with respect and staff knew each resident's individual preferences. The inspector heard staff addressing residents by their preferred names and speaking in a clear, respectful and courteous manner. Since the previous inspection, all residents living in shared bedrooms had received a centre specific risk assessment in relation to the suitability, safety of this arrangement and to determine if this arrangement was in keeping with the wishes of the resident. The person in charge outlined how these assessments also assisted her in identifying any residents who presented with responsive behaviours (a term used to describe how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) that could potentially impact on the safety and welfare of either residents in these rooms. The person in charge outlined to the inspector how choices had been afforded to residents living in shared bedrooms after suitable consultations and agreement with the resident and when appropriate, their representatives.

The inspector noted that some residents with dementia had responsive behaviours. Some behaviours described as problematic by staff included verbal and physical aggression however, there were suitable care and support arrangements in place for

residents who presented with responsive behaviours. For example, the inspector found that staff had suitable training and the necessary skills and knowledge to work with residents who had behavioural issues. Records evidenced that staff training on responsive behaviours had been provided in January 2018 and this training was now included in the staff induction programme. Staff spoken to by the inspector outlined person centred interventions including utilising the use of activities, music, walks in the garden and distraction techniques. Files examined showed that assessments and care plans for these residents were person centred. Staff positively and socially interacted with residents and implemented suitable interventions to prevent boredom which may sometimes trigger responsive behaviours. Files examined showed that a pre-admission assessment had been completed in all cases to ensure that the centre could meet the needs of the residents. Staff had received training in documenting episodes of responsive behaviours in Antecedent, Behavior and Consequence assessment charts (ABC charts). These charts were formally analysed and used to create an individual care plan for each resident. The inspector noted from a sample of care plans that these ABC assessments contained sufficient detail and appropriate interventions to provide consistent approach to care. Choices were offered where possible and respected and environmental triggers such as noise levels were generally controlled. There was evidence that appropriate referrals had been made to mental health services. Recommendations from the community psychiatric services had been implemented along with person centred interventions with positive outcomes for residents including a reduction in the incidence of responsive behaviours.

Staff were working towards promoting a restraint free environment. Additional equipment such as low beds and alarm mats were available to reduce the need for bedrails. Staff confirmed that bed rails were often used at the request of residents and residents who spoke with the inspector confirmed this. Safety checks were completed and there was documented evidence that these were undertaken. All forms of restraint were recorded in the restraint register and appropriately notified to HIQA. Risk assessments had been undertaken and care plans were put in place for residents who used bedrails.

Judgment:

Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

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

Findings:

There was evidence that residents including residents with dementia or and their representatives as appropriate, were consulted with and participated in the organisation

of the centre. Overall, residents' rights, privacy and dignity were respected, during personal care, when delivered in their own bedroom or in bathrooms. Residents spoken with confirmed that they were afforded choice in relation their daily lives and for example, receive visitors in private. There were no restrictions to visiting in the centre and the inspector observed several visitors at different times throughout the two day inspection. The nursing assessment included an evaluation of the resident's social and emotional wellbeing. Since the previous inspection a number of improvements were noted in relation to resident consultation. For example, completion of residents' satisfaction surveys which gave residents and/or residents representatives an opportunity to give feedback. There had been a morning breakfast club established following consultations with residents. The inspector spoke to some of the residents who were part of a small group who choose to attend the dining room for breakfast. Residents to whom the inspector spoke were very pleased with this new development and found it to be a pleasant social opportunity.

The daily routine was organised to suit the residents and all staff including catering staff optimised opportunities to engage with residents and provide positive connective interactions. Organised activities were provided and other small group or one to one activities were facilitated by activities staff which reflected the capacities and interests of each resident including residents with cognitive impairment. The inspector spoke to the activities coordinator who had worked in the centre for a number of years and knew all residents very well. He outlined how choices in relation to activities were offered to residents including residents with dementia where possible. Residents' individual preferences were respected. The inspector observed that residents were free to join in an activity or to spend quiet time in their room. A social assessment had been completed for each resident which gave insights into each residents' history, hobbies and preferences. Each resident's preferences were assessed and this information was used to plan the activity programme. Activities included bingo, music, quizzes, and religious ceremonies. Some residents said they preferred not to take part in the group activities and the inspector saw that their wishes were respected and individual one to one time was scheduled for these residents, if appropriate. Staff created opportunities for one-to-one engagement, for residents who were unable or unwilling to participate in groups. The inspector concluded that the person in charge and staff worked to create an environment for residents with dementia that minimised the risk of responsive behaviours.

The inspector spent time observing staff interactions with residents, including residents with dementia. These periods of observation took place in the dining room and day room and the majority of interactions were rated as positive connective care. There was evidence that residents' with dementia received care in a dignified manner that respected his or her privacy. Staff were observed knocking on residents' bedroom doors and seeking the residents permission before engaging in any care activity. There were no restrictions on visiting times; there were facilities to allow residents to receive visitors in private with rooms separate to residents' bedrooms where visitors and residents could meet. Numerous visitors were observed throughout both days of inspection where staff members knew the names of visitors and vice versa. Staff took time to talk with family members both when they visited and when they rang to enquire about their relative. Residents with dementia were consulted about how the centre was run and the services that were provided. The person in charge regularly spoke to all residents and there were

regular residents' meetings. The most recent held in February 2018 and issues raised by residents were acted upon by management. Representatives were welcome to represent residents who were unable to verbally communicate or could not attend the meetings.

The centre had developed a number of methods of maintaining residents' links with their local communities, including copies of the local/parish newspapers and visits by transition year students from the local schools. Residents had access to a hands free phone and a number of residents had their own mobile phones. Residents had access to the daily national newspapers and several residents were observed enjoying the paper on both days of inspection. Residents had access to radio, television, and information on local events. Residents were facilitated to exercise their civil, political and religious rights. Residents' religious preferences were facilitated through regular visits by clergy to the centre and the inspector observed mass being celebrated on the first morning of inspection which was held once a week. In addition, there was weekly administration of the sacrament of the Eucharist in the centre. The inspector observed that residents' choice was respected and control over their daily life was facilitated in terms of times of rising /returning to bed and whether they wished to stay in their room or spend time with others in communal rooms. The inspector observed that some residents were spending time in their own rooms, watching television, or taking a nap.

Judgment:

Compliant

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

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

Findings:

The actions required from the previous inspection had been completed. There was a centre specific complaints policy that had been most recently reviewed in January 2018 and, which was prominently displayed and met the regulatory requirements. Copies of the complaints process were also stored in the residents' information packs and copies of these packs were located in a number of locations such as the sitting rooms. Residents to whom the inspector spoke said that they had easy access to any staff in order to make a complaint. The person in charge was identified as the named complaints officer and residents stated that they felt they could openly report any concerns to her and were assured issues would be dealt with. The inspector noted that the provider representative also monitored complaints through the regular management meetings. Records showed that complaints made to date were dealt with promptly and the outcome and satisfaction of the complainant was recorded. There was a second nominated a person, other than the person in charge, available in the centre to ensure that all complaints are appropriately responded to and that the person in charge

maintained the records specified under in Regulation 34 (1)(f). The complaint process included a local appeals procedure and there was also an independent appeals process. The residents guide also held details of the complaints policy and independent appeals process was included.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

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

Findings:

All the actions from the previous inspection had been completed and a number of new staff had been recruited with additional staffing hours allocated each day. For example, since the previous inspection healthcare assistant hours had increased by two hours in the morning and three hours in the afternoon. The operations manager who previously worked part time was now working full time and there was an additional staff nurse allocated on for some shifts to enhance the available skill mix.

There were sufficient staff with the right skills, qualifications and experience on duty over the course of the inspection to meet the assessed needs of the residents. Copies of rosters given to the inspector showed that these were normal arrangements and staffing levels at the weekend were similar to the staffing arrangements during the week. Residents and relatives spoke positively of staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity. This was seen by the inspector throughout the inspection in the dignified and caring manner in which staff interacted and responded to residents. Staff who spoke with the inspector confirmed that staffing levels were sufficient, as did residents. The majority of staff were long-term employees and knew the residents, management and the operation of the centre well.

There were systems of communication in place to support staff with providing safe and appropriate care. There were handover meetings each day to ensure good communication and continuity of care from one shift to the next. However, the person in charge agreed to review the format of the morning handover to ensure that it met their communication and supervision needs. The inspector saw records of regular staff meetings at which operational and staffing issues were discussed. Staff also had available to them copies of the regulations and standards. In discussions with staff, they confirmed that they were supported to carry out their work by the person in charge. The inspector found staff to be well informed and knowledgeable regarding their roles, responsibilities and the residents' needs and life histories. There was evidence that residents knew staff well and engaged easily with them in personal conversations. Staff

were allocated to various sections of the centre where they remained and were only rotated periodically. The person in charge outlined how this system ensured staff remained working with the same group of residents to allow them to get to know the residents well. The person in charge also outlined how this approach was of particular value to residents with dementia, as it facilitated the development of therapeutic relationships between staff and residents and their families.

Records demonstrated that staff were up to date with mandatory training and some staff had also received additional training such as training in dementia care which incorporated training in responsive behaviours. Mandatory training was up to date which included training in fire safety, safe moving and handling, and safeguarding vulnerable persons. Other training provided included infection control, end of life, food and nutrition, hydration and the management of dysphagia. Nursing staff confirmed they had also attended clinical training including medication management, and care planning. The inspector saw and staff confirmed that there was on going professional development training and staff were encouraged to attend training and education sessions. The activities coordinator who providing activities in the centre had undertaken activity training and described various activities that were provided in the centre, including gentle exercises and one to one activities.

There were effective recruitment processes in place and staff were suitably inducted. Recently recruited staff confirmed that training in responsive behaviours had been included in their induction programme. Staff were appropriately supervised and annual appraisals were conducted for staff. The requirements of schedule 2 of the regulations were in place in the sample of staff files reviewed as were up-to-date registration with relevant professional bodies. A vetting disclosure was in place in all files reviewed and the operations manager gave assurances that all staff working in the centre had a vetting disclosure in place.

Judgment:
Compliant

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
The inspector found that overall the design and layout of the centre was suitable for its stated purpose. The centre had recently been a new purpose built extension which opened in December 2017. This extension provided residents with additional facilities such as additional toilets, a therapy room, a large sitting area, a new oratory and 13 ensuite single ensuite bedrooms that had given the centre a total capacity to

accommodate 48 residents. The centre was a single storey, purpose built nursing home. Residents had access to a safe internal garden area that was well maintained. The premises were clean, generally well maintained, adequately heated, with adequate natural lighting and ventilation. However, paintwork in some areas was marked or damaged by friction from beds and other equipment and required attention. The building was wheelchair accessible.

Overall there was adequate space and storage facilities were provided to residents for personal possessions including lockable storage. Communal areas comprised a large sitting room, a second smaller sitting room where residents could relax in a quiet environment, three dining rooms, and a smoking room.

Residents' private accommodation was provided in three wings and the centre was registered to accommodate a total of 48 residents. All bedrooms had wash hand basins. There were 23 single bedrooms and two twin bedded rooms, all with full en suite facilities. The remainder of the bedrooms did not have ensuite facilities and consisted of two single bedded, three twin-bedded rooms, three three-bedded rooms, and one four bedded room. Overall, there was an adequate number of toilets and assisted showers suitably located in the premises to meet the needs of residents. On the days of inspection the size and layout of bedrooms was suited to meeting the needs of residents, including those with high dependency needs. The inspector noted that there were 15 vacancies in the centre on the days of inspection. The person in charge outlined how she therefore had considerable options/choices to offer to residents regarding their choice of accommodation. The person in charge outlined to the inspector how reconfiguration of the existing bedrooms had occurred to maximise space available in multi-occupancy bedrooms. Shared bedrooms had appropriate screening for residents' privacy. Televisions, wardrobes and bedside lockers were available to all residents. The inspector spoke with residents that lived in shared bedrooms who said that they were happy living in their bedrooms. The person in charge also outlined how she was cognisant of the dependency levels of residents admitted to sharing rooms as outlined in the statement of purpose.

Residents with dementia were accommodated in each of the three wings. Residents had access to a number of communal day rooms, these provided adequate space, were comfortable and homely. Since the previous inspection the provider representative had made some changes to dining arrangements and meals were provided in three dining rooms. The inspector noted that these arrangements helped facilitate mealtimes to be social occasions. The inspector noted that the front sitting room was a popular area with residents and visitors. Quieter rooms and a small oratory was available to residents for quiet reflection and prayer. Both communal rooms and all common areas were furnished and decorated to create an interesting environment for people with dementia. Circulation areas, toilet facilities and shower/bathrooms were seen to be free of obstacles and most areas including bathrooms, were adequately equipped with hand-rails and grab rails. However the bedroom corridor in the new wing did not have any hand rails installed. The person in charge informed the inspector that these rails had been ordered and would be installed shortly. The inspector found residents were enabled to move around as they wished. There was some signs and pictures that had been creatively used in the centre to support residents to be orientated to where they were. For example, there were numbers on bedroom doors and some signage on doors

in some areas to indicate their function such as the nurses office, dining room and the sitting rooms. However, improvements were required to the signage to support residents particularly residents with a cognitive impairment find their way around the centre. Toilet seats had a contrasting colour and toilet doors and hand rails had been painted a contrasting colour and to support residents with dementia and those with visual impairment. Working call bells were accessible from each resident's bed and in each room used by residents. Resident's bedrooms were personalised with soft furnishings, ornaments and family photographs. A number of bedrooms seen contained a flat screen television with remote control. There were clocks located in a number of locations including the large sitting room. However, the person in charge agreed to review the availability of clocks and wall calendars available to support residents with memory loss and help promote orientation. Additional rooms included a cleaning room, visitor's toilet, a recently refurbished residents' wet room/toilet, a storage room and a therapy/treatment room. There was also a lower floor in the basement which was used as storage space, office space and staff facilities. The outside grounds were still to be landscaped following completion of the extension and these would provide an additional large enclosed patio area available to residents.

A separate kitchen was located off the main dining room. The inspector observed the kitchen to be visibly clean and well-organized and reviewed the most recent environment health office report. The inspector visited the laundry and found that it was adequate to meet the needs of the residents. However, the inspector requested the person in charge to review the design, size and layout of the laundry in the context of the centre being at full capacity of 48 residents. Assistive equipment where required, was provided to meet the needs of resident and each resident requiring hoisting was provided with individualized lifting sling. Records viewed confirmed that equipment was serviced regularly. However, there was some minor premises improvements required including a number of ceiling lights did not have any shades and one toilet door lock was in need of repair as it was broken.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Since the previous inspection there had been improvements in the systems for hazard identification and risk management in the centre. Staff had received training in incident and accident reporting and there was a recording system in place and all accidents and incidents were recorded via this system on centre specific incident forms. All were

reviewed by the person in charge, the operations manager, assistant director of nursing and provider representative. There was evidence of suitable actions in response to individual incidents. There was a risk register available which covered for example, risks such as residents' falls, fire safety risks and manual handling risks. There was a center specific safety statement that was dated as being reviewed in December 2017. The operations manager and the provider representative and the person in charge met each month to review health and safety issues including any incidents, accidents or near misses. This meeting also reviewed procedures and practices including risk management and fire safety in the center. The records of incidents and accidents recorded a low incidence of slips, trips and falls. Records seen were adequate to ensure arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents. Clinical risk assessments were undertaken, including falls risk assessment, assessments for dependency and assessments for pressure ulcer formation. There was recorded information/communication with relevant persons such as the person in charge, the residents' GP, next of kin, the clinical observations taken and any learning/changes required to prevent reoccurrence. However, the hazard identification process required improvement to include a risk assessment of the unsecured access to the therapy room.

Overall there were suitable fire safety measures in place and there were completed logs maintained on daily, weekly, monthly basis in relation to fire safety. There were also records of quarterly tests and checks of fire equipment, doors, exit routes and emergency lighting. The inspector noted that the emergency lighting and the fire alarm were most recently serviced in March 2018. Certification of testing and servicing of extinguishers, were documented as serviced in November 2017. There were fire and smoke containment and detection measures in place in the premises. All staff had received training in fire safety within the past 12 months. Staff spoken to were familiar with what actions to take in the event of a fire alarm activation and with the principles of horizontal evacuation. Practiced fire drills were held regularly and the records viewed contained details of each evacuation including a note of the competency of staff in the use of evacuation equipment such as evacuation sheets. These records also identified where improvements to the procedure could be made. Practice fire drill records also included the fire scenario that was being simulation during the practice. All residents had personal emergency egress plan's (PEEP's) which identified the level of mobility and evacuation mode for each resident. Copies of the PEEP's were available in a number of locations including the nurse's office near the entrance for ease of retrieval. These plans included the level of cognitive understanding, the need for supervision and the level of compliance of each resident in an emergency situation. The person in charge confirmed that a small number of residents smoked tobacco. A policy was in place and referenced the requirement for a smoking risk assessment for all residents who smoked. From a review of a sample of care plans, there were suitable risk assessments for each resident that individually risk assessed each resident's capacity to smoke safely. The inspector saw that where controls were required such as a fire retardant apron and staff supervision; that these were implemented in practice. There were procedures to be followed in the event of fire that were displayed in a prominent places throughout the centre including in each residents' bedroom. However, some of these fire safety notices required improvement to ensure that they were easily understood by residents and visitors.

Manual handling practices observed were seen to be in line with current best practice and the training matrix recorded that all staff were trained in manual handling. With the exception of the new bedroom corridor, all other circulation areas, toilets and bathrooms were adequately equipped with handrails and grab-rails. The absence of hand rails in the new wing has been actioned under outcome 6 of this report. Overall there were suitable governance and supervision systems in place to monitor residents at risk of falls and such arrangements were reviewed on an on-going basis by the person in charge. Staff working on day and night duty reported to the inspector that they monitored and checked on residents including residents with dementia at regular intervals. All residents had records of when these monitoring checks had been conducted. There was a risk register available in the centre and the inspector found that overall the hazard identification process was adequate. There was a centre specific risk management policy that had been most recently reviewed in November 2016. This policy addressed the identification and assessment of risks and the controls that were in place including the requirements of the regulations. The policy covered the identification and assessment of risks and the precautions in place to control the risks identified. However, some improvement was required to the way hazards were being risk rated/recorded in the risk management policy, as some records viewed were not in compliance with the centres' risk management policy.

Overall the premises, including the communal areas and bedrooms were found to be clean and there was adequate standard of general hygiene at the centre. There were systems to support staff knowledge and implementation of best practice to ensure good infection prevention and control were in place. For example, regular training of staff, subtle staff infection control reminder notices and strategically placed hand sanitizer dispensers located throughout the premises. There was personal protective equipment such as latex gloves and plastic aprons available in designed areas. The training matrix confirmed that staff had completed training in hand hygiene and infection prevention and control and staff that were spoken with demonstrated knowledge of the correct procedures to be followed. The provider representative outlined how a new cleaning system including a new cleaning trolley were about to be implemented in the centre. However, the cleaning practices as described by some staff was not adequate to prevent cross contamination and required review.

Judgment:

Non Compliant - Moderate

Outcome 08: Governance and Management

Theme:

Governance, Leadership and Management

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

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

Findings:

On the previous inspection in November 2017 it was identified that improvements were required in relation to the governance and management in the centre. However, on this inspection there was evidence of improvements in the governance and management arrangements. These included the completion of all actions required from the previous inspection, the implementation of a quality management system including structured auditing and reporting system which included regular formal governance meetings. There was evidence of increased management and staffing resources such as protected managerial time for the assistant directors of nursing and the operations manager who had been part time was now working full time in the centre. There was evidence of improved oversight for example, unannounced out of hours monitoring visits had been conducted by the person in charge. In addition, there had been an increase in staffing levels and the recruitment of additional staff including staff with particular skills to augment the existing skill mix. For example, the person in charge outlined how since the previous inspection a senior nurse with a particular skill set and experience in the management of challenging behaviors had been employed in the centre. There had also been an increase in staff nurse and healthcare staff hours to increase the overall skill level.

There was a clearly defined management structure which clearly identified management arrangements for out of hours and at weekends. The provider representative worked full time in the centre and was well known to residents. The provider representative confirmed that all staff including those recently recruited had the required vetting disclosure as required under the 2013 Regulations and the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012 to 2016. In addition to the provider representative, the person in charge and the operations manager, there were also two assistant directors of nursing available to provide management and clinical support. Since the previous inspection, a senior healthcare assistant position had been created to further strengthen the management and supervision within the centre. Staff and residents were able to identify who was in charge and what the lines of accountability were. On both days of this inspection the person in charge, the provider representative and the operations manager made themselves available to the inspector and attended the feedback meeting at the end of the inspection.

The person in charge confirmed that she had regular informal and formal meetings with the provider representative, and minutes were maintained for the formal meetings. The inspector was provided with copies of the minutes of these meetings and noted that they were focused on a number of issues including matters such as residents, complaints, staffing, health and safety issues, and building renovation/maintenance.

The provider representative, person in charge and staff demonstrated a commitment to on-going improvement and quality assurance. There was evidence of quality improvement strategies and monitoring of the service. The provider representative provided a copy of the annual report into the safety and quality provided in 2017 which included an quality improvement plan for 2018. There was an across-the-board system of audit in place, capturing a number areas, to review and monitor the quality and safety of care and the quality of life of residents. For example, there were audits in relation to medication management, food and nutrition, safeguarding and safety, residents rights, privacy and dignity, wound care and care planning.

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:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Sacred Heart Nursing Home
Centre ID:	OSV-0005557
Date of inspection:	04/04/2018 and 05/04/2018
Date of response:	22/05/2018

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

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.

1. Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding

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

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:

The care plan is formally reviewed and revised if necessary at a minimum of every 4 months or sooner if required; in consultation with the resident and where appropriate the residents family.

All nursing staff, the Director of Nursing and senior occupational Therapist attended NMBI category 1 approved care Planning training on the 24th of April 2018.

Proposed Timescale: 14/05/2018

Theme:

Safe care and support

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

To ensure that the records set out in Schedules 3 are complete including records of stock medication are kept in a designated centre and are available for inspection by the Chief Inspector.

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 formal medication audit is completed every 4 months when all medication records are formally audited by the pharmacy. A new system of auditing the medication records has been introduced, whereby the ADON is completing a medication audit on a bi-monthly basis in house.

Proposed Timescale: completed and on-going

Proposed Timescale: 14/05/2018

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

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 including ensuring that all areas are suitably decorated, that all toilet door locks on are fully functioning and ceiling lights

have light shades.

3. 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:

There is an on-going planned upgrading of premises including planned paintwork and decorating, Improved signage, improved Availability of clocks and calendars. This is discussed at monthly management meetings and planned accordingly.

The Toilet door lock had just broken and was repaired by the maintenance team the day of the inspection.

As advised to the inspector the current ceiling lights are being reviewed by the electrician to provide recessed lights. If there are areas where hanging lights remain shades will be fitted.

Proposed Timescale:

Paintwork and decorating: 31st July 2018 and on-going due to constant wear and tear

Lampshades: 31st July 2018

Increased Signage: 30th June 2018

Proposed Timescale: 31/07/2018

Theme:

Effective care and support

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

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 including suitable adaptations such as hand rails on bedroom corridors, as may be required to be provided for residents.

4. 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:

Handrails had been ordered for the new extension prior to the inspection and we had been waiting for installation. They have since been put in place and all circulation areas now have handrails in place.

Proposed Timescale: 14/05/2018

Outcome 07: Health and Safety and Risk Management

Theme:

Safe care and support

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

To ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre including the unsecured access to the therapy room.

5. Action Required:

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

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

The risk management policy and risk register is being reviewed and updated.

The access to the Therapy room has been reviewed and this door now has a combination lock on it ensuring that only those requiring access, can now access this room.

The risk register will be audited regularly to ensure that the policy meets practise. All staff will be requested to feed into risk identification by ensuring risk management is discussed at staff meetings and also as part of the daily report.

Proposed Timescale: 30/06/2018

Theme:

Safe care and support

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

To ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified are recorded in compliance with the centres' risk management policy.

6. Action Required:

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

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

The risk management policy and risk register is being reviewed and updated.

The risk register will be audited regularly to ensure that the policy meets practise. All staff will be requested to feed into risk identification by ensuring risk management is

discussed at staff meetings and as part of the daily report.

Proposed Timescale: 30/06/2018

Theme:

Safe care and support

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

To ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

7. Action Required:

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

A new cleaning system has been introduced including the purchase of a new cleaning trolley, which prevents cross contamination between different areas in the nursing home. Cleaning staff have received training in this.

Proposed Timescale: 14/05/2018

Theme:

Safe care and support

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

To display a clear and suitable record of the procedures to be followed in the event of fire in a prominent place in the designated centre.

8. Action Required:

Under Regulation 28(3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

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

As referenced in the report, there were fire safety notices displayed throughout the centre. These notices are now being updated in consultation with the nursing home engineer to ensure they are more accessible to residents with communication and cognitive impairments.

Proposed Timescale: 30/06/2018