Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Sacred Heart Residence
Name of provider:	Little Sisters of the Poor
Address of centre:	Little Sisters of the Poor, Sybil Hill Road, Raheny, Dublin 5
Type of inspection:	Unannounced
Date of inspection:	02 August 2022
Centre ID:	OSV-0000157
Fieldwork ID:	MON-0037440

About the designated centre

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

Sacred Heart Residence is owned and operated by the Little Sisters of the Poor, and is located near St. Anne's Park in Killester on the northside of Dublin. The centre can accommodate 86 residents, both male and female over the age of 65, with low to maximum dependency levels. Residents are accommodated in 84 single bedrooms and 1 double bedroom, all with en suite facilities. Other facilities available to residents include sitting rooms, a shop, tea bar and a chapel.
The person in charge is supported by the registered provider representative, a chief nursing office, a clinical nurse manager. There is team of registered nurses and healthcare assistants who provide care to the residents in the centre. Allied health professionals are contracted to provide specialist services to the residents in accordance with their wishes and needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	76

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 2 August 2022	08:30hrs to 18:05hrs	Niamh Moore	Lead
Tuesday 2 August 2022	08:30hrs to 18:05hrs	Jennifer Smyth	Support

What residents told us and what inspectors observed

The atmosphere in the centre was calm and relaxed, and a sense of well-being was evident. The general feedback from residents was that they were happy living within the designated centre. Residents' comments regarding staff were very positive, reporting to inspectors that the staff were "very kind' and that "they couldn't do enough for you". From the inspectors' observations, staff appeared to be familiar with the residents' needs and preferences, and were respectful in their interactions. All residents who spoke to inspectors reported they felt safe and secure in the centre.

On entering the building, the inspectors were guided through the centre's infection prevention and control procedures, by the centre's receptionist. These processes included recording of temperatures, a declaration of being symptom free, completing hand hygiene and the wearing of face masks.

Following an introductory meeting, the inspectors did a walk-around the nursing home with a member of management. The designated centre consists of 86 registered beds which were set out over three floors, the first, second and third floors. The centre had an additional two floors, the basement and ground floor with no resident accommodation located, however these areas located additional communal areas and staff facilities such as the kitchen, laundry, storage areas and office spaces. There were lifts and stairs to facilitate movement between these areas. Residents also had access to safe and well-maintained internal gardens.

The centre was divided into five units on the day of the inspection; Dom Marmion, Mountain View, St Teresa, Jon Vianney and St Joseph. Each unit had lounge and dining areas. In addition, there were several communal rooms such as the hairdressing room, a chapel, a physiotherapy room, an art and pottery room, an activity room and a smoking room. The premises was large and rooms were of a sufficient size to meet residents' needs. However, inspectors noted that within communal areas there were a large amount of ornaments which displayed high levels of dust. The external windows were also visibly dirty which reduced the homely environment provided.

The designated centre had mostly single bedrooms with one twin bedroom. All rooms had en-suite facilities. Resident's bedrooms were seen to be comfortable spaces, and were well maintained and personalised with pictures and photographs.

Residents were seen to receive visitors throughout the day of the inspection. Visits took place in bedrooms but there was additional communal space available for residents' and visitors to use if they wished. Visitors who spoke with inspectors were satisfied with the unrestricted visiting arrangements in place. They were happy with the communication they received from the designated centre, stating that they felt they were kept updated in relation to any changes to their loved one's condition.

There was a monthly schedule of activities and a daily activity advertised throughout the centre. On the day of the inspection, a therapeutic activity delivered as group and individual sessions for people with dementia was held on the first floor. Daily mass was available at 11am, a quiz and one to one activities and crafts were carried out in the afternoon. A resident told inspectors that they enjoyed attending the activities as it was nice to have something to look forward to. The centre had independent advocacy services advertised on public notice boards.

The inspectors observed that mealtimes in the centre were relaxed and social occasions for residents, who sat together in small groups at dining tables. Residents were observed to chat with other residents and staff. One resident told inspectors that "the food is excellent", remarking that "the standard has really gone up". A daily menu was displayed for some residents, however not all dining areas had a menu displayed. Inspectors spoke with two residents who were not aware of the lunch menu. Staff reported that they had asked residents their meal preference from the previous evening. There were no pictorial menus available to assist residents who had communication difficulties. Staff reported that for these residents, staff were aware of their likes and dislikes. However, in the event of new or temporary members of staff assisting residents with meals, this would not always be the case.

Staffing levels were not seen to be appropriate. Supervision at mealtimes was at times reduced to one staff member in the large dining room on the ground floor, and to no staff present in the smaller dining room on the first floor. It was observed that some of the residents had specialised dietary and fluid requirements, therefore increasing the risk of choking. In addition, the dining room on the third floor had no staff present while residents were having their breakfast. Supervision at meal times required action in order to maintain each resident's safety.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

The provider had progressed some areas of the compliance plan following the previous inspection in April 2021 and improvements were found in relation to mandatory training, the availability of some records, the risk management policy and activity provisions. Inspectors found that action was required by the registered provider to address the areas of oversight for medicines management as an urgent compliance plan was issued relating to Regulation 21: records of medicines and Regulation 4: the failure to adhere to the medicine management policy for the designated centre. The registered provider provided the Chief Inspector with the necessary assurances. In addition, staffing resources required review, and auditing and governance systems required strengthening which will be further discussed

within this report.

The Little Sisters of the Poor is an unincorporated body and is the registered provider for Sacred Heart Residence. The senior management team consists of a superior provincial, a person delegated management responsibility on behalf of the registered provider and a person in charge.

The person in charge was supported in their role by a Chief Nursing Officer and a clinical nurse manager. Other staff resources included staff nurses, healthcare assistants, activity personnel, housekeeping, maintenance, administration and catering staff. During the inspection, the inspector reviewed worked and planned rosters and found there was insufficient non-clinical staffing levels in place and that a review of the allocations of clinical staff was required to ensure there was appropriate supervision within communal areas.

Staff had access to mandatory training which included fire safety, manual handling, infection control and safeguarding of vulnerable adults. There was a training plan developed for 2022 to ensure high levels of compliance was sustained. Staff were supervised in their roles with key members of management working Monday to Friday. A senior staff nurse was delegated responsibility at the weekends and the person in charge was on call.

Schedule 5 written policies and procedures were available for review within the designated centre. Inspectors found evidence where the medicine policy for the designated centre had not been followed relating to the prescribing, storing and administration of medicines to residents.

A review of a sample of two staff files provided assurances that information required under Schedule 2 of the regulations was maintained to ensure documentation required, such as references and evidence of vetting from An Garda Siochana were in place. In addition, inspectors found that improvements had been made since the last inspections in November 2020 and April 2021 relating to the oversight of records. Records requested during the inspection were accurate, up to date and accessible. However, as previously stated within this report, an urgent compliance plan was issued relating to the management of records for medicines within the designated centre.

Inspectors reviewed records of management meetings within the centre and found that data captured and discussed had improved with greater oversight. There was a variety of meeting forums which met on a regular basis, such as quarterly safety meetings, monthly clinical governance meetings and weekly management meetings. Meeting minutes were seen with agenda items such as occupancy, staffing, training, health and safety, infection control, fire and audits. A quality indicator report with resident information was also compiled and trending on information such as falls, restraints, injuries, wound and skin integrity, medicines, complaints and hospital admissions. However, despite these improved systems, inspectors found that there were gaps in the oversight arrangements particularly on the auditing systems. Auditing in areas such as infection control and medicines management had not identified findings of inspectors. While audits on areas such as care planning and the

environment, had similar findings to inspectors, there was ineffective action to respond to these findings and sustain improvements as these findings remained on the day of the inspection. Examples of these gaps are discussed further under Regulation 23: Governance and Management.

The registered provider had completed an annual review of quality and safety of the service for 2021. There was evidence that residents' feedback was incorporated within this review. There were quality improvement plans identified for 2022, such as reducing bed rail usage within the centre, training for staff on dementia awareness and reviewing the cleaning schedules of each unit to improve cleaning.

Regulation 15: Staffing

On the day of the inspection, inspectors were not assured that there was a sufficient number and skill mix of staff for the assessed needs of residents and the size and layout of the designated centre. For example:

- The dining rooms in two units were unsupervised throughout the inspection day. Inspectors observed that this occurred during the breakfast and lunch time meals.
- Cleaning staff were not effectively planned, organised or managed to meet the service's infection prevention and control needs. Cleaning staff were required to assist with catering duties and there was insufficient numbers of cleaning staff rostered. For example, cleaning staff were rostered until 1pm most days with some units having no cleaning staff on duty at weekends. This resulted in areas throughout the centre remaining unclean and was a repeat finding from the inspection dated April 2021.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff had access to mandatory training within the designated centre. In addition, supplementary training was offered on areas such as dementia care.

Inspectors saw evidence that new staff were appropriately supervised through induction documentation.

Judgment: Compliant

Regulation 21: Records

The registered provider had failed to ensure that the following records set out in schedule 3 were available in respect of each resident of the designated centre:

- A record of each drug and medicine administered signed and dated by the nurse administering the drugs and medicines in accordance with any relevant professional guidelines. For example, inspectors observed that three residents' medicines were left unsupervised in a dining room. Two residents were not present and one resident had not taken the medicines that was left in front of them. When reviewing the medicine administration record, these medicines had been signed for as administered.
- A record of on-going medical assessment, treatment and care provided by a person's medical practitioner where that information is available. For example, six medicine prescriptions in use on the day of the inspection, were seen to be out of date as they had not been reviewed within the last four months.

An urgent compliance plan was issued following the inspection in relation to the above matters.

Judgment: Not compliant

Regulation 23: Governance and management

- While the registered provider had been proactive in carrying out a fire safety risk assessment, the actions taken to mitigate some of the immediate risks as identified in the risk report had not been completed. For example, items that were categorised as red risk rating such as compartmentation, testing the fire alarm and repairs to fire doors. These items which had been identified since February 2022, were due to be actioned immediately.
- Some audits seen did not drive quality improvements within the centre. For example:
    - An environmental audit on 08 June and 04 July 2022 identified high levels of dust within the centre, however this had not been appropriately actioned. These audits also did not have overall percentage findings.
    - A medicine management audit in May 2022 found 98% compliance, however this audit tool did not verify if medicine prescription were reviewed and in date and did not review the storage of medicines on the ground floor.
    - A care plan audit dated April to May 2022 found 67% compliance with findings relating to end-of-life and psychosocial care planning. There was a quality improvement plan due to be completed by 15 June 2022, however this remained incomplete on the day of the inspection.

Judgment: Not compliant

Regulation 4: Written policies and procedures

Inspectors were not assured all policies set out in Schedule 5 were implemented. For example:

- Medicine prescriptions were to be reviewed every four months as per the designated centre's medicine policy. However, from a sample of medicine prescriptions viewed, inspectors found that six were not reviewed within the required four months.
- The medicine round according to the centre's medication policy was a protected time, however according to staff spoken to this was not the case which could lead to near-misses or medicine errors.
- In addition, inspectors also found that there was not an effective system to ensure as per the policy, appropriate disposal of medicines.

An urgent compliance plan was issued following the inspection in relation to the above matters.

Judgment: Not compliant

Quality and safety

Residents had good access to health care and there was evidence of good recreational opportunities being provided to residents. Residents were consulted about the organisation of the designated centre. However, action was required in assessment and care planning, restraints, the premises, infection control, fire precautions and medicines management to ensure that they complied with the relevant regulations.

Inspectors reviewed a sample of five residents' records. Comprehensive assessments were not available for two residents prior to admission. Improvements were required under Regulation 5 as inspectors were not assured all residents' needs were assessed and appropriate care plans developed. For example, inspectors were told that a resident had a keen interest in gardening, however this was not reflected in their care plan.

Residents had timely access to medical, health and social care professionals. Inspectors were told that a general practitioner (GP) visited the centre weekly or as required. Access to specialised services such as a geriatrician and psychiatry of later life were available when required through a referral system. Residents had good access to on-site services such as physiotherapy and occupational therapy.

Residents' records showed that residents had access to services such as dietetics, speech and language therapy and tissue viability nursing (TVN). Residents were facilitated to access the services of the national screening programme.

The designated centre had a policy on the use of restraint and a restraints register in place. There were a number of restrictive practices observed and reviewed on the day of the inspection. Residents' consent was obtained or if they were unable to provide consent, discussions were held within the multi-disciplinary team and family members. Restraint use was also seen to be discussed regularly at management meetings and was part of the centre's action plan developed for 2022 to reduce bed rail usage. While inspectors found that bed rails were used in accordance with national policy, other forms of restrictive practice such as sensor alarms and restricted access to the outside for some residents had not been appropriately risk assessed.

Inspectors were assured that all reasonable measures were taken to protect residents. Staff spoken with had good knowledge and access to the appropriate training in relation to the detection, prevention of and responses to abuse.

An activity coordinator had been appointed following the last inspection and had developed an activity programme in the centre. Inspectors noted that there was a varied programme of activities available for residents and observed that many staff engaged actively in providing meaningful activity and occupation for residents throughout the day of inspection. Staff made good efforts to ensure the residents' rights were upheld in the designated centre and care was seen to be person-centred. Residents were supported to exercise choice in terms of when they decided to get up and how they chose to spend their day. However, inspectors observed that meal time menus were not readily available on all units. There were a variety of systems in place to ensure that residents were consulted in the running of the centre and played an active role in the decision making within the centre. This consultation occurred through carrying out resident surveys and residents' meetings. The residents' survey returned mostly positive feedback for the centre.

The provider had arrangements in place to support residents to receive their visitors with ongoing safety measures in place, such as temperature checks and health questionnaires for visitors. Inspectors observed a number of visitors coming and going throughout the day of the inspection.

There was adequate space for residents to meet their visitors in areas other than their bedrooms if they wished to do so.

A number of areas within the designated centre such as flooring and paint work on doors were seen to require maintenance. In addition, the designated centre had one double occupancy bedroom which was not configured to accommodate two residents. Inspectors were informed that it was the intention of the provider to reduce this room to single occupancy and they agreed to submit an application to the Chief Inspector to vary conditions one and three of their registration.

Inspectors reviewed the risk management policy, safety statement and risk register for the designated centre. A process for hazard identification and assessment of

risks was in place and subject to regular review.

The registered provider had made personal protective equipment (PPE) available to staff. However, staff were observed not to use their PPE correctly as per Public Health and Infection Prevention and Control guidelines on the Prevention and Management of Cases and Outbreaks of COVID-19, Influenza and other Respiratory Infections in Residential Care Facilities. In addition, inspectors found that a number of areas under infection control required review, for example fridge temperature logs which were required to be completed daily had gaps, which was a finding from a previous inspection. In addition, a staff member spoken to was not aware of the correct fridge temperatures. Further findings are discussed under Regulation 27: Infection Control below.

Inspectors were provided with evidence that the registered provider was in the process of reviewing fire precautions to address fire safety concerns within the designated centre. The registered provider had contracted a competent person to complete a fire risk assessment in February 2022. Inspectors requested that an action plan be submitted to the Chief Inspector with timelines to respond to all identified risks. Most staff spoken with were clear on what action to take in the event of the fire alarm being activated. Despite these measures being in place, inspectors found that the provider was failing to fully protect residents from the risk of fire which will be further discussed under Regulation 28: Fire Precautions.

On the day of inspection, inspectors were not assured staff were following professional guidelines or the designated centre's own policy in relation to medication practices, in particular relating to the safe storage, administration and reconciliation of medicines.

Regulation 11: Visits

The centre had a visiting policy in place which reflected unrestricted visits, which was in line with public health guidance.

Judgment: Compliant

Regulation 17: Premises

Inspectors found that the premises was not in accordance with the designated centre's statement of purpose. Inspectors viewed the one twin bedroom within the designated centre and found it was not configured to allow for two occupants. On the day of the inspection, this room was occupied by one resident.

Action was required by the registered provider to ensure that the premises

conformed to all of the requirements set out in Schedule 6 of the regulations.

- All areas were not seen to be kept in a good state of repair. Paint work on doors and architraves were seen to be badly marked, flooring was seen to be badly stained in some dining rooms and items of equipment such as some sinks and a kitchen trolley were eroded.
- Safe floor covering was not provided in all areas. Flooring was seen to be lifting in some areas, in particular at a fire exit door on the lower ground floor.
- The temperature of water was excessively high in communal bathrooms which posed a risk of scalding. While signs were displayed in communal bathrooms to warn residents of hot water, inspectors found that this was insufficient to provide residents with anti-scalding protection.

Judgment: Substantially compliant

Regulation 26: Risk management

A risk management policy was in place that addressed the requirements of the regulations.

Judgment: Compliant

Regulation 27: Infection control

The provider failed to ensure that care was provided in a clean and safe environment that minimised the risk of transmitting a healthcare-associated infection. For example:

- The premises were not seen to be clean in all areas, there were high levels of visible dust in communal areas.
- The windows were visibly dirty which hampered residents being able to see outside.
- Fridges were seen to be damaged and unclean which posed a risk of cross contamination.
- Napkins and napkin rings on tables set up for lunch were seen to be visibly dirty. The napkin rings had names selotaped onto them, therefore could not be effectively cleaned.
- The centre's seating was mostly soft furnishings. There is a risk of cross infection as these furnishings would be difficult to clean in between use.
- One out of two bedpan washers in the centre was out of order on the day of the inspection. Staff informed the inspectors they cleaned commode basins in the resident’s en-suite bathroom using the shower head. This practice could

lead to cross contamination.

- Soaps were seen to be contained in individual hand dispensers and bars of soap were on sinks. This could lead to cross infection.
- Communal items were seen in the hairdresser's room and barbers which included hair brushes, razors and shampoos.
- Hand towels were not available at every sink which posed a risk of cross infection.
- A sharps bin was not signed and dated, and did not have the temporary closure mechanism engaged when they were not in use to ensure they were stored safely. Another sharps bin while signed and dated, was over three quarters full, this bin had been opened in April 2021. These practices could pose a risk of exposure to blood-borne viruses.
- While the laundry facility did have a separate entrance and exit for clean and dirty laundry, clean laundry was seen to be placed in an unclean area. This increased the risk of cross contamination.

Staff did not consistently adhere to standard infection control precautions. This was evidenced by staff who were not bare below the elbow as recommended in local hand hygiene guidelines. Inspectors observed six staff were wearing watches and bracelets. In addition, four staff members were seen to be wearing their masks inappropriately.

Judgment: Not compliant

Regulation 28: Fire precautions

The current systems in the centre did not support effective arrangements for the safe evacuation of residents in the case of a fire. For example:

- While the registered provider had recently commissioned new floor plans, on the day of the inspection, the new floor plans were not located beside the fire panels on individual units, to guide staff in the event of a fire.
- Personal emergency evacuation plans (PEEPs) were insufficiently detailed to guide staff on evacuating residents in the event of a fire. For example, they did not contain details of the residents' understanding and compliance with their PEEP. For one resident, the PEEP did not detail additional communication aids they required from staff.
- Fire drill records did not provide assurances that staff were adequately prepared for the evacuation of residents in the event of a fire. For example, the registered provider had not simulated the evacuation of the largest compartment with the lowest number of staff available within the last year.
- Three sets of corridor double doors did not fully close.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors were not assured that all medicinal products were administered in accordance with the directions of the prescriber. One resident's medicine which was in capsule format was seen to be in a pot of pureed apple. The risk of the capsule medicine outer shell dissolving was increased as the resident had not arrived to the dining room and the medicine was left in the puree.

Inspectors were not assured that all medicinal products were stored securely in the designated centre. For example, inspectors observed three residents' medicines were unsecured in the dining room and the keys for the controlled medicines were not kept on the nurse's person, instead they were in a locked cupboard in the ground floor treatment room.

Action was required to ensure that all medicinal products no longer required by a resident were disposed of in accordance with national legislation. For example:

- Out of date medicine was stored in the medicine trolley, this was not segregated.
- Flu vaccines from last year had not been returned and were seen to be stored in a medicine fridge.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A comprehensive assessment was not available for two out of two residents reviewed by inspectors prior to their admission. This was a repeat finding from the last inspection of April 2021.

While care plans examined were seen to be reviewed at four monthly intervals, they were not revised as changes had occurred, for example:

- A resident's skin integrity had been reviewed by the TVN, however the recommendation of the TVN had not been adhered to. For example, it was recommended that photographs of the resident's skin were to be taken to determine the healing progress. Inspectors found that there was no photographic records available for review within the resident's notes.
- A resident's end-of-life care plan, did not include information which related to their psychosocial needs.
- The care plan for a resident, who had displayed exit seeking behaviours, did not reflect this behaviour.
- Social care plans did not sufficiently guide staff to support residents' activities and psychosocial needs. For example, one resident's care plan did not detail life history, social interests or hobbies. Another resident admitted to the

designated centre six months previously did not have a care plan in place.

Judgment: Not compliant

Regulation 6: Health care

The inspectors found that residents had access to appropriate medical and allied health care support to meet their needs. Records showed that residents had access to medical treatment and appropriate expertise in line with their assessed needs, which included access to consultants in gerontology and psychiatry of later life as required.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Some restraint used in the centre was not in accordance with national policy as published by the Department of Health. For example, no risk assessment was carried out for sensor alarms to identify if these were the most appropriate measures to put in place. In addition, access to the outdoors was restricted for some residents and had not been risk assessed.

Judgment: Substantially compliant

Regulation 8: Protection

Inspectors reviewed documentation relating to one safeguarding incident notified to the Chief Inspector. Evidence was seen that the incident was investigated with appropriate safeguarding measures put in place within a timely manner.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors spent time observing residents and staff engagement and found that residents' rights were upheld. There were facilities in place for recreational activities and residents were observed throughout the day spending time in the communal

areas and enjoying taking part in the activities on offer. Residents had access to daily newspapers and TV.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Sacred Heart Residence OSV-0000157

Inspection ID: MON-0037440

Date of inspection: 02/08/2022

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: - Staff allocations were reviewed and clinical supervision during mealtimes in all dining areas is now in place. - Menus are now displayed in all units. Completed 20/08/2022 - Picture menus are currently being developed and completed. - Recruitment of housekeeping staff to cover shift in the afternoons and weekends to be completed. - Recruitment of housekeeping supervisor to oversee the housekeeping team, manage, plan, and organize cleaning schedules.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: - Medicine Kardex prescriptions were reviewed and updated immediately with the most recent medication review recorded, completed on 05/08/2022. Going forward the CNO/CNM will monitor and ensure that this is completed on a four monthly basis.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and	

management:
- Compartmentation fire alarm testing was completed on 12/08/2022.
- The medication audit tool was reviewed and updated to include review of medicine prescription and storage of medication. Completed 25/08/2022.
- The environmental Hygiene audit tool was reviewed and revised to ensure findings are actioned within a timeframe and the audit will reflect an overall percentage finding.
- Care plan audit action plans from April to May Audit are being completed along with the four monthly care plan review.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
- All staff is made aware that the medication rounds is a protected time and nurses should not be interrupted while giving medication to residents to prevent the occurrence of near- miss or medication errors. The CNM/CNO/PIC is available for support when needed.
- Disposal of out-of-date medications will now be included in the monthly medication stock check to ensure expired medications are disposed of appropriately.
- The key to the MDA drug press is now being held by the nurse in Dom Marmion.
- Installation of MDA drug press on each floor is underway and to be completed by 30/10/2022.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
- An application to reduce the double room into a single room occupancy will be submitted to the chief inspector to vary conditions one and three of the registration. To be completed by 28/02/2023.
- All fixtures and fittings were logged in the maintenance book, floor coverings needing attention were fixed/replaced and completed by 09/09/2022.
- There are 2 bedpan washers within the home, one bedpan washer remains out of order. Plan to replace the bedpan washer if parts cannot be sourced by servicing company.
- A company is arranged to carry out an audit of the temperature of the sinks in the communal areas.
- A plan for Paintwork on doors and architraves is currently being assessed for implementation.

- Kitchen trollies that are found to be eroded will be replaced.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
- Cleaning procedures were reviewed in each unit. A meeting with housekeeping staff was held on 12/09/2022 to discuss cleaning and dusting on all areas.
- Communal items in the barber's room such as shampoo, hairbrush, and soap found on the sink were removed.
- Resident's name selotaped on napkins rings were removed.
- Window cleaning is underway to be completed by 30/09/2022.
- The sharps bin was replaced, signed, and dated.
- Met with laundry staff and discussed about placement of clean and dirty laundry, signage in place.
- Appropriate use of masks, wearing of jewelry and, wrist watches will be monitored in the monthly hand hygiene audit.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
- The new floor plans are being revised to be located beside the fire panel.
- The PEEP plan for the resident requiring additional communication aids was updated to guide staff with evacuation in the event of fire.
- A night fire drill was carried out on 23/08/2022 and 13/09/2022 and will continue as a monthly fire drill.
- The three doors have been fixed by the maintenance team and are now closing properly.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

- All nurses were directed to discharge their duties and responsibilities regarding medication administration. A medication competency assessment for all nurses is currently being conducted. 30/09/2022.
- The MDA drug press key is now being held by the nurse in Dom Marmion.
- Installation of MDA drug press on the unit floor is underway and to be completed by 30/10/2022.
- All trolleys were checked and out of date medicines were returned to pharmacy. This will be part of the monthly stock checking. Out of date medicines in the medicine trolley and flu vaccine in the medicine fridge were removed.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
- A revised comprehensive pre-assessment form is in use and from January 2022 all residents had a comprehensive pre-assessment completed before they were admitted to the Centre. The pre-assessment is conducted by the PIC, CNO, and CNM or delegated SN.
- Photographic records of wounds are now recorded within the resident's care plan.
- End of life care plans are currently being reviewed and completed.
- The care plan of the residents with exiting behaviour has been updated to reflect this behaviour.
- Social care plans are currently being updated and completed to detail the resident's activities and psychosocial needs.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
- Risk assessments for the use of sensor mats which are in place for the safety of the
- resident have now been completed. Completed 30/08/2022.

- - Access to the outdoors is not restricted to any residents they have access to the gardens and the grounds around the Centre. However, residents who display exiting behaviours and are at high risk for absconding have been risk assessed and have specific care plan and monitoring in place. A resident who has exiting behaviour are allowed to access the garden and grounds with no restrictions but in a case where

the resident is heading out to the gate the receptionist will immediately notify the staff on the unit to supervise the resident. This is to ensure that the resident protected from any danger.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	30/10/2022
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Substantially Compliant	Yellow	28/02/2023
Regulation 17(2)	The registered provider shall, having regard to	Substantially Compliant	Yellow	30/11/2022

	the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.			
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Red	05/08/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/10/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	30/10/2022
Regulation 28(1)(e)	The registered provider shall ensure, by means	Not Compliant	Orange	30/09/2022

	of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/09/2022
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Substantially Compliant	Yellow	30/11/2022
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Substantially Compliant	Yellow	05/08/2022
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of	Substantially Compliant	Yellow	05/08/2022

	the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.			
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.	Substantially Compliant	Yellow	30/08/2022
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Red	30/09/2022
Regulation 5(2)	The person in charge shall	Not Compliant	Orange	30/09/2022

	arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	30/10/2022
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	20/08/2022