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Sacred Heart Residence, OSV-0000157, 20 June 2018

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**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Sacred Heart Residence
Centre ID:	OSV-0000157
Centre address:	Little Sisters of the Poor, Sybil Hill Road, Raheny, Dublin 5.
Telephone number:	01 833 2308
Email address:	ast.raheny@lspireland.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Little Sisters of the Poor
Lead inspector:	Sarah Carter
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	84
Number of vacancies on the date of inspection:	2

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:
20 June 2018 08:45	20 June 2018 17:00
21 June 2018 08:45	21 June 2018 17:00

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	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Substantially Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Compliant
Outcome 04: Complaints procedures	Compliance demonstrated	Compliant
Outcome 05: Suitable Staffing	Substantially Compliant	Compliant
Outcome 06: Safe and Suitable Premises	Compliance demonstrated	Compliant

Summary of findings from this inspection

This inspection report sets out the findings of an unannounced thematic inspection which focused on six specific outcomes relevant to dementia care. The purpose of the inspection was to determine what life was like for residents with dementia living in the centre. The inspection also followed up on any actions required from previous inspections and considered any information received by the Health Information and Quality Authority (HIQA) in the form of notifications.

Overall the service had sufficient numbers of staff, who were working to maintain or improve the residents well being. Care provided was at a good level and staff were knowledgeable about the residents' they cared for. Residents with dementia had their needs met, and were offered freedom and dignity within the center due to staff practices and the layout of the premises. However the documentation and care

planning needed improvement. This had also been a finding in the center's previous inspection in July 2017. Care plans were not up to date with information regarding the residents current needs, and the daily records did not reference the care plans of the residents. There was good access to general practitioners (GPs), specialists and allied health professionals including dieticians, physiotherapists and speech and language therapists.

The center was large and spacious and offered residents appropriate environments in which to mix, and the privacy to be alone if they wished. Communal areas were decorated with comfortable furniture and décor to make the areas appear more homely.

The provider had completed a self assessment tool on dementia care, and had assessed the center as compliant in five of the six outcomes and substantially compliant in a sixth outcome (the outcome that looks at staffing). The person in charge and management team had implemented an action plan to address this substantial compliance by planning training days for staff. The training days were to take place shortly after the inspection.

The inspector found that health and social care outcome was moderately non-compliant, due to the gaps and inconsistencies in care planning across a range of issues. The safeguarding and safety outcome was substantially complaint due to the shortfalls in staff training in the areas of safeguarding and the management of behaviors that challenge. The inspector found the staffing outcome to be compliant, and the specific training deficits were addressed in the safeguarding and safety outcome.

Across the remaining three outcomes on residents rights and privacy, complaint management and safe and suitable premises there was a good level of compliance with the requirements of the Health Act 2007, Care and welfare of Residents in Designated Centre's for Older People Regulations 2013 (as amended) and the national standards for Residential Care Settings for Older People in Ireland.

These findings are described in more detail in the body of the report and in the action plan at the end of the report.

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Residents well being and welfare was being maintained, and evidence based care was being delivered but there were inconsistencies identified in care planning.

As part of the inspection a wide range of care plans were reviewed of residents with dementia and residents who were displaying some deterioration in their cognition, but did not have a formal diagnosis of dementia.

In the centre's last inspection (July 2017), inconsistencies had been noted in care planning. The actions identified by the provider and person in charge to address this issue focused on improving the recording and practices around giving medication as needed (PRN medications). While the practices around as required medication in this inspection did not raise any concern, issues were found across a wide range of care plans. The inspector also highlighted that improvements were required in care planning, and in the linking of care planning to the daily nursing records.

It was also noted in the last inspection (July 2017) that staff were getting used to the new computerised system of maintaining residents notes. Staff have now been using the system for over one year. Some care plans were up to date and had been reviewed within the four month requirement, however others had not been updated, and it was not easily deciphered whether those care plans were still in use, or required. Duplications were also noted across care plans which had different names, thus increasing risk to residents that staff may not follow the most up to date care plans. Consultation with the resident on the development of their care plan was also not consistently recorded.

Daily notes did not routinely capture residents activities throughout the day, and it was not possible to ascertain whether residents care plans for their activity preferences were up to date, as comments on their attendance or the impact of the activity had on their well being was not consistently recorded across a wide range of records reviewed.

Some additional records of care and treatments were maintained outside of the computerised system, for example medical notes and records of communication with residents families. Records of residents wishes for their death (advanced directives), were also kept in hard copy. These advanced directives were discussed with the residents and / or family on admission to the centre, however in the sample reviewed they were several years old, and had not been reviewed recently, increasing the risk that any change a residents and / or families may make to their preference for end of life care may not be captured.

Overall staff were knowledgeable about residents, knew their needs and how they preferred their treatment, and there was access to a wide range of evidence based tools and specialist input available to meet residents needs and maintain or improve their well being. The specialists included physiotherapy, a dietician and a speech and language therapist. Residents also had a choice of GP, however up to 75% had opted to be treated by the nursing homes GP service. Records reviewed showed residents had been referred appropriately to specialists, and there were contemporaneous notes by the specialists. There were policies and procedures in place to guide practice, these included, policies on communication needs, dementia care and end of life care.

Residents spoken to expressed high levels of satisfaction with the care they were receiving, a number stated that they were feeling better since they moved to the centre. They felt the staff were attentive and available, and that their call bells were answered quickly if they needed assistance.

Residents had comprehensive admission assessments in place, and information was transmitted on transfer to hospital and received on their return to the centre. Resident's medications were regularly reviewed by the resident's GP. Medication practices were reported on and demonstrated by staff and were in line with requirements.

Food appeared nutritious and choices were offered. There were drinks and snacks available throughout the day. Assistance to eat was offered, and residents had a choice on where they ate their meals. Staff who were working in the dining rooms were knowledgeable about residents needs and any specific requirements they had. Residents chose their meals daily for the following day, but could change there minds on the day if they wished.

Judgment:

Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

Some action(s) required from the previous inspection were not satisfactorily

implemented.

Findings:

Residents spoken to reported they felt safe in the center, and there was an up to date detailed policy in place to guide staff on safeguarding and caring for residents with responsive behaviors.

Residents rights were safeguarded by an up to date policy and staff knowledge of potential safeguarding concerns. Staff reported they knew the policy and were able to outline the steps they would take if they had a concern. There had been no recent incident or allegations regarding safeguarding for the inspector to review. A significant number of staff were not up to date in their training, with a large staff group due for training in the fortnight after inspection. Of the group that were scheduled for re-training, the training records indicated they had last received safeguarding training in 2014 and 2015. Training dates for night staff were yet to be confirmed.

There was an up to date policy in place to guide staff on caring for residents with responsive behaviors. Staff were able to report and describe the behaviors of residents who displayed behaviours that challenge. There were very few residents in the center who displayed responsive behaviors and the staff were knowledgeable about how to care for them. The care plan for managing their behaviors were reviewed and found to be adequate. However an incident of wandering was recorded in narrative notes and were not found to have been addressed in the care plans.

The inspector found that there were bedrails in use for just under a quarter of residents and there was widespread gaps in the documentation regarding the use of bedrails. Assessments for the use of the restraint (bedrails) were not easily located, the trials of alternative measures were not consistently recorded, and the nursing narrative notes did not indicate that the bedrails were in nightly use.

In the last inspection (July 2017); the actions requires to address the substantially complaint judgment included the recording and reviewing of alternatives to restraint and increasing staff knowledge on the use of restraint. This remains a finding from this inspection.

Judgment:

Substantially Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The inspector found that resident's privacy and dignity was respected in the centre, and residents were supported to make choices and exercise control over their day to day lives.

Residents who required assistance with eating were given assistance in smaller private dining rooms. Residents who were more independent were encouraged to attend and eat in a large dining room on the ground floor. The inspector observed dining experiences in both settings, and noted there was pleasant interaction between staff and residents in the ground floor dining area when required, but in the dining rooms where more assistance was offered to residents the atmosphere was quiet and the interaction between staff and residents were task orientated. Residents reported the food was good, and they liked the choices on offer. There was drinks and snacks available throughout the day, and residents could opt to eat in their rooms if they wished. The dining area observed were pleasantly decorated with table cloths, however the menu was supplied by staff, and was not available on the table or in pictures on close by noticeboards to orientate and remind residents what was on offer. For less active residents there was bird cages on some units, and pleasant seating area sand balconies throughout the building. All bedrooms seen had their own television and radio. The daily newspapers were available to residents and there was also a shop onsite for residents to purchase day to day supplies.

There was large amounts of space and facilities available for residents recreation. The space included a library, with a stock of large print books, several quiet meeting rooms, a pottery room, and an auditorium where concerts and large group activities took place. There was an activity timetable in place, sections of which were provided by volunteers, and there was an electric bicycle / rickshaw available, manned by volunteers, for residents to enjoy the local park and seafront. Due to the volume of activity provision by various sessional staff and volunteers, it was not always clear in residents daily notes their attendance at activity and the impact on them. This has been discussed in Outcome 1 above. There was a daily roman catholic mass in the centre, and the church onsite was also used for the local community, giving a pleasant busy community atmosphere to the morning routine in the centre, although residents who did not wish to attend reported to the inspector they did not feel obliged to go.

There was a communication policy in place which guided practice, however the care plan reviewed around communication was not up to date with the practice being used by staff. Care plans have been discussed in detail in Outcome 1.

There were regular residents' meetings, and minutes were reviewed of the last two meetings. Many topics were covered, and feedback was given on actions completed from previous meetings. Information was available to residents in the form of a residents booklet, which was easy to read and available throughout the center. A satisfaction survey and a quality assurance survey had been distributed amongst residents and their relatives, and a small number of replies were available for the inspector to view. Feedback was largely positive within these questionnaires, and the person in charge was knowledgeable about the responses and any requests contained within. Advocacy services were available in the centre, and this detail was advertised in the residents information booklet. No residents spoken to had used the advocacy service, but were aware they could ask for support if required.

There was no restrictions on visitors, and multiple spaces throughout the building for visits to be facilitated. Visitors were observed coming in and out of the center, and the log book at reception was well maintained.

Judgment:
Compliant

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
The center had a policy on complaints and a procedure for residents or their representative was advertised and included in the residents information booklet. policy named a complaints officer and a nominated person to oversee the management of complaints.

There was a complaints record in place, with one complaint having been received in 2018 to date. The complaints officer was clear in the response to the complaint and the action taken to address the concerns raised. The centers governance team was in the process of introducing a concerns log for each of the units in the center, to capture any day to day issues or concerns that residents or their relatives might raise. Complaints received and the findings of the investigations were discussed at governance meetings.

Residents who spoke with the inspector said they did not have any complaints, and were complimentary about the service they received and the staff they dealt with, but in the event that they did they knew the procedure on how to raise them.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

No actions were required from the previous inspection.

Findings:

The number and skill mix of staff in the center was suitable and sufficient to meet the needs of residents. There was a roster in place, and it was accurate and matched the staffing on duty on the day of inspection. There was sufficient support staff available in catering, householder and administrations. There had been some turnover in staffing in the earlier part of this year, but there was no vacancies on the day of inspection. Residents spoken to emphasised that they liked the staff, and interactions observed on the units were kind and personalised. There was very few agency staff in use in the centre, and where possible the same agency staff member was requested. There was a gender mix of staff across both day and night shift, in keeping with the centre's policy on meeting residents' preferences for their care.

The staff who the inspector spoke to were knowledgeable about a range of procedures; including fire and reporting safeguarding allegations. However some staff were overdue to receive training in managing behaviors that challenge and safeguarding. Fire prevention training was up to date. In the center's self assessment, this outcome was rated at substantially complaint, on the basis that there was gaps in the training records of staff. As discussed above, this shortfall is judged in Outcome 2, and there was safeguarding training days scheduled for the weeks following the inspection dates for 27 staff.

Staff were supported on each unit by a senior nurse, and a member of the religious order that manage the nursing home.

There was a large group of volunteers in the center. In the files received, all had garda vetting in place and had title for the sort of volunteering they were involved in, for example, manning reception or working in the shop. However the person in charge and other members of the governance team agreed with the inspector that these descriptions should be expanded with more details of the volunteers' roles.

It was confirmed on the days of inspection that all current staff had received garda vetting disclosures.

Judgment:

Compliant

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

The Centre was built in the 1970s, and was large and spacious. The premises was found to be compliant and meet all the requirements of the regulations.

There is no specific dementia unit, and residents with a formal diagnosis of dementia or cognitive impairment with various levels of dependency live in all units. Each unit has a mix of men and women. Bedrooms are mostly single and en-suite, and there is one twin en-suite bedroom. There are residents accommodated on the first, second and third floors, with the ground floor rooms in use for recreational purposes, meeting rooms and offices. Upper floors were accessible by three lifts and wide staircases with handrails. The rooms and facilities available on the ground floor for recreation have been described earlier in the report and because of their accessibility and specific designation as activity rooms meant that residents activities were uninterrupted by passers by or other activities that staff needed to carry out.

All bedrooms seen were spacious and had call bells appropriately placed and within reach of beds and seating. En-suite bathrooms were spacious and had handrails where required. Corridors were long and wide, all had handrails, however there few rest stops or seating areas and the governance team agreed to review this at the end of the inspection. There was ample sitting rooms and communal areas, and residents had freedom to move throughout the building and access the garden area if they wished. The center was well located close to a bus route, a nearby park and other local amenities. Residents told the inspector that they often went out and about. There was appropriate amounts of storage for any adaptive equipment that was in use, and residents had good amounts of personal storage in the bedrooms. Residents had personalised their bedrooms with their own possessions and in some cases, pieces of furniture. In the centers dementia care policy the use of colour and signage was identified to assist residents with dementia find their way around such a large building. Suitable signage was evident around the building and on the bedrooms of residents who needed it.

There were adequate numbers of communal bathrooms spread throughout the building and most were near or close by the sitting rooms on units.

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:

Sarah Carter
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Sacred Heart Residence
Centre ID:	OSV-0000157
Date of inspection:	20/06/2018
Date of response:	

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:

There was duplication across care plans with different titles.

Some care plans seen were out of date and / or had not been updated within the 4 month timeframe.

Consultation with residents in the development of their care plans was not consistently recorded.

Daily records of care did not reference the key aspects of the resident's care plans.

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

1. Action Required:

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

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

We are revising the layout of our care plan software to achieve the following: minimise duplication; create a location to clearly record care plan reviews; create a location to clearly record resident's activity care plan and their engagement in activities; create a location to record resident's (or representative's) engagement in care planning

We will complete a review of all care plans

We will create a schedule of care plan review that will be directly supervised by nurse managers;

We will provide guidance to inexperienced nursing staff in resident assessment and care planning.

Proposed Timescale: 30/09/2018

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

Safe care and support

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

Staff require up to date knowledge in the management of responsive behaviours (18 staff last received training in 2016, and 11 staff received training in 2018).

2. Action Required:

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

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

Provide training and workshop on managing behaviours that challenge and ensure that all staff have attended training in the last 2 years.

We will maintain accurate records of content and attendance for this training.

Proposed Timescale: 30/09/2018

Theme:

Safe care and support

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

Documentation on the assessment and rationale for bedrails was not clear, the trials of alternatives to bedrails were not documented.

3. Action Required:

Under Regulation 07(3) you are required to: 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.

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

We will complete a reassessment of all residents who currently use bed rails

We will document alternatives considered.

We will document consent to any bed rails that remain in place.

We will establish a schedule for reassessment of bed rail use.

Proposed Timescale: 06/09/2018

Theme:

Safe care and support

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

Staff training in safeguarding was not up to date and training dates for night staff were not identified.

4. Action Required:

Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

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

The staff who have not attended training on Safeguarding Vulnerable Adults within the last two years will attend training by 15/9/2018.

An accurate record of those that have attended will be maintained.

A schedule of training will be established to ensure ongoing compliance with this.

Proposed Timescale: 15/09/2018