

# eDeposit Ireland

## Sacre Coeur Nursing Home, Station Road, Tipperary Town, Tipperary

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**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Sacré Coeur Nursing Home
<b>Centre ID:</b>	ORG-0000278
<b>Centre address:</b>	Station Road, Tipperary Town, Tipperary.
<b>Telephone number:</b>	062 51157/ 33339
<b>Email address:</b>	selma.kelly@sacrecoeur.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Sacré Coeur Nursing Home Limited
<b>Provider Nominee:</b>	Selma Kelly
<b>Person in charge:</b>	Laura Myers
<b>Lead inspector:</b>	Mary Moore
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	25
<b>Number of vacancies on the date of inspection:</b>	1

## About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgements about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

**Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality 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 ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

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

From: 09 December 2013 10:00 To: 09 December 2013 19:30

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

Outcome 02: Contract for the Provision of Services
Outcome 03: Suitable Person in Charge
Outcome 05: Absence of the person in charge
Outcome 06: Safeguarding and Safety
Outcome 07: Health and Safety and Risk Management
Outcome 08: Medication Management
Outcome 09: Notification of Incidents
Outcome 10: Reviewing and improving the quality and safety of care
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints procedures
Outcome 18: Suitable Staffing

**Summary of findings from this inspection**

This inspection was unannounced, took place over one day and was the fourth inspection of the centre by the Authority. The inspector met with residents, relatives, and staff members, observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures, complaints records, fire safety and risk management records and staff files. The inspection findings were satisfactory; the centre was effectively governed and operated within the parameters of the Regulations, there was an ongoing and effective system for reviewing the quality and safety of the care and services and the quality of life of residents; previous action plans had been satisfactorily addressed and there was evidence to support a transparent and accountable culture of care. On the day of inspection there were 25 residents living in the centre on a long term basis, the feedback received from residents and relatives was positive and while staff were busy there was a pleasant and relaxed atmosphere in the centre.

The inspection reviewed 12 of a maximum 18 outcomes and found that the centre was fully compliant in six outcomes and minor non-compliances were identified in five outcomes. While the inspector found that the premises was in an excellent state

of repair and decorative order and maintained to a high standard, it was not purpose built and consequently was in moderate non-compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland. The provider confirmed the progression of plans to address the limitations of the premises.

**Section 41(1)(c) of the Health Act 2007 Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.**

**Outcome 02: Contract for the Provision of Services**

*Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.*

**Theme:**

Leadership, Governance and Management

**Judgement:**

Non Compliant - Minor

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

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

**Findings:**

The provider confirmed that contracts were in place for all but one resident who was very recently admitted.

The inspector reviewed a random sample of four contracts for residents' living in the centre for longer than one month. Each contract clearly set out the overall fee for care and services provided, any monies received from state support services, the residual fee for which the resident was liable and the fees charged for services not included in the basic fee. However, the contracts were not dated when signed therefore it was not possible to definitively state that they were agreed within one month of the residents admission.

**Outcome 03: Suitable Person in Charge**

*The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.*

**Theme:**

Leadership, Governance and Management

**Judgement:**

Compliant

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

No actions were required from the previous inspection.

**Findings:**

The person in charge had worked as the Director of Nursing since July 2009 but prior to that had worked in the centre as both a staff nurse and nurse manager from January 2006 to July 2009. She was a registered children's nurse and a registered general nurse and evidence of her current registration with her regulatory body was in place. As one of two directors of Sacre Coeur Nursing Home Ltd, she had enhanced authority, responsibility and accountability for the governance, operational management and administration of the centre. This was evident in her interactions with the inspector during the inspection. The inspector found that the person in charge was competent, fully informed in relation to each resident's needs and care plans and had robust systems in place for the ongoing monitoring and review of the design and delivery of care and services to residents. These are discussed throughout the body of the report. The person in charge continued to participate in ongoing professional development and had since the last inspection undertaken education and training in the management of challenging behaviours, performing venepuncture, manual handling and cardiac first responder. Systems were in place for the transfer of learning gained to all staff.

**Outcome 05: Absence of the person in charge**

*The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**

Leadership, Governance and Management

**Judgement:**

Compliant

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

No actions were required from the previous inspection.

**Findings:**

The person in charge confirmed that she had not been absent from the centre for any period of time that required notification to the Authority. Adequate arrangements were in place for the replacement of the person in charge on a routine or unexpected basis; two key senior managers (KSM) were available.

This is a family owned and managed business and all persons participating in the management of the centre (PPIM) and their presence in the centre were detailed on the staff rota, an on-call rota operated at weekends. The inspection findings support that the operational management of the centre was effective and met the centres stated purpose, aims and objectives.

**Outcome 06: Safeguarding and Safety**

*Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.*

**Theme:**

Safe Care and Support

**Judgement:**

Non Compliant - Minor

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

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

**Findings:**

As evidenced in staffing recruitment and training records, nursing and medical records, complaints records, audits and minutes of meetings the inspector was satisfied that measures were in place for the protection of residents from any form of harm or abuse and that the resident and their care was central to the ethos of the centre. The provider confirmed that there had been no incident of alleged, suspected or reported abuse of any resident.

The person in charge said that training for all staff on protection issues was to date provided annually. Staff training records seen indicated that all staff currently employed had received training, that staff attendance was monitored by the provider and any identified gaps were addressed in November 2013. The person in charge had also completed "train the trainer" training specific to protection in November 2013. Twenty staff had also in November 2013 attended education and training on responding to and caring for residents with challenging behaviours. The inspector saw that residents were relaxed in the company of staff, that there was a good level of visitor activity, staff responded promptly to residents and staff were described as "good" and "caring".

The centre had recently audited its financial practices and as a consequence had revised its policy and procedures on the management of residents' finances and personal property. The policy was centre specific, recognised the provider's liability under Article 26(2) and was very clear on the procedures for invoicing and receipting.

A policy on the prevention, detection and response to any alleged, reported or suspected abuse was in place but it did not provide an alternative reporting pathway for staff in the event of an allegation against a member of the management team.

**Outcome 07: Health and Safety and Risk Management**

*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**

Safe Care and Support

**Judgement:**

Compliant

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

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

**Findings:**

There was substantial evidence of the provider's commitment to protecting and promoting the health and safety of residents, staff and visitors.

The fire register was very well maintained and from it the inspector readily retrieved certificates from competent persons confirming that all fire detection, fire containing, life-saving and fire fighting equipment was inspected, tested and serviced in line with legislative requirements. In addition records were maintained of the inspection and testing of all such equipment on a daily, weekly or monthly basis by staff with evidence of remedial action taken as necessary. The inspector saw that designated fire escape routes were clearly indicated and free of obstruction; centre-specific fire action notices were prominently displayed. Staff training records indicated that training was provided to staff by an external competent person annually and most recently in January and February 2013. Fire drills were undertaken six-monthly, assistive devices were in place and each resident had a readily accessed detailed personal emergency evacuation plan (PEEP) that was reviewed on a weekly basis by staff. There was physical evidence of completed fire safety upgrading works as requested by the local fire officer.

There was a fire evacuation and an emergency plan in place that outlined for staff the contingencies in place and on a six monthly basis the person in charge re-instructed staff on the emergency plan, the evacuation plan and the missing resident policy and procedure.

There was a policy in place for the identification, recording and management of accidents and incidents and this is discussed further in Outcomes 9 and 10.

The risk management policy was reviewed in July 2013 and the inspector was satisfied that risks were managed in practice. Circulation areas and bathrooms were adequately equipped with handrails and grab-rails. A risk management procedure for the stairs chair-lift was prominently displayed and seen to be adhered to. A preventative contract for its inspection and maintenance was in place. Access to high risk areas was restricted; signage was in place advising visitors when exiting the premises as to the security and safety of residents. The inspector saw that the policy and procedures in relation to resident smoking had been addressed. Individualized risk assessments were in place and the inspector saw that the identified controls were implemented by staff. While a further control was recommended by the inspector this was implemented prior to the conclusion of the inspection. The inspector saw that signage and secure storage was in place for personal protective equipment and chemicals and no deviation was noted.

Staff training requirements in manual handling were monitored by the provider and were within mandatory requirements. Staff had access to four lifting devices and certificates of their thorough inspection in June 2013 were in place. Each resident was

seen to have a manual handling plan that referenced the staff assistance and equipment required; the plans was also kept in a separate folder for easy access for staff. An audit of manual handling including direct observation of practice was completed in June 2013.

Based on her observations the inspector was satisfied that adequate arrangements were in place for the prevention and control of infection. Staff had access to an evidence based suite of policies and the equipment necessary to implement these policies including a blood and body fluid spillage kit. Clinical risk waste was securely stored internally and externally. The laundry though compact was tidy and organised, adequately equipped with evidence of the risk assessment and segregation of linen. The provider had completed a comprehensive audit of infection prevention and control procedures with evidence of remedial action taken such as the replacement of defective soap dispensers. The sluice room was adequately equipped and a bedpan washer was in place and operational, however the room was dual purpose and not conducive to effective infection prevention and control as it was also utilised by environmental hygiene staff. This is actioned under Outcome 12, the premises.

### **Outcome 08: Medication Management**

*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**

Safe Care and Support

**Judgement:**

Non Compliant - Minor

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

No actions were required from the previous inspection.

**Findings:**

There was evidence to support safe medication management practices.

Practice was governed by a comprehensive medication management policy. There was documentary evidence of good communication and working arrangements with the relevant pharmacy.

The inspector saw that the management of controlled drugs was in line with legislative requirements and regulatory body guidance. All medications were securely stored including those for return to the pharmacy. Itemised, signed and countersigned records were maintained of the these.

Medical authorisation was in place for the administration of medication in an altered format (crushed).

A sample of residents' medication prescription and administration records satisfied regulatory requirements and no deficits or errors were noted by the inspector. Each

record was signed and dated by the relevant General Practitioner (GP).

Medication management practice was audited quarterly by the person in charge and errors or near misses were recorded in the incident book; there was evidence of action taken to enhance the quality and safety of practice.

A medication competency assessment had been completed in November 2013 with all nursing staff with no issues of concern noted. Nursing staff did not routinely transcribe prescription records.

There was a procedure in place for the quarterly review of each resident's medication regime. However, what was not evident was the action taken on foot of any recommendations to ensure that each resident benefited from their medication.

### **Outcome 09: Notification of Incidents**

*A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*

**Theme:**

Safe Care and Support

**Judgement:**

Compliant

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

No actions were required from the previous inspection.

**Findings:**

The person in charge was diligent in exercising her legal responsibilities in relation to the submission of notifications to the Authority and the maintenance of accident and incident records in the centre. The inspector reviewed each notification on its submission and again prior to the inspection. In the centre the inspector saw that any incident that resulted in harm or injury to a resident was reviewed and investigated and corrective action plans were implemented as necessary. Each accident and incident record was comprehensive and satisfied the documentary requirements of Schedule 3.

### **Outcome 10: Reviewing and improving the quality and safety of care**

*The quality of care and experience of the residents are monitored and developed on an ongoing basis.*

**Theme:**

Effective Care and Support

**Judgement:**

Compliant

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

No actions were required from the previous inspection.

**Findings:**

Fundamental to the good practice and level of compliance evidenced was the provider's ongoing review of the design and delivery of care and services to residents and the learning gained from such reviews.

The inspector saw that an annual audit schedule was maintained and a comprehensive range of audits had been completed in 2013; these have been referenced throughout the report and included medication management, the use of physical restraint, staff training, complaints, financial procedures, wound care, accidents and incidents and residents' rights dignity and consultation. There was evidence of feedback to residents, staff and relatives as appropriate.

The system of review included consultation with residents and relatives. Eighteen residents/relatives had responded to a satisfaction survey completed in May 2013 with the majority rating care and services as good or excellent. The provider reported that the residents committee was now quite active and beneficial. Minutes seen by the inspector indicated that meetings were convened every second month with residents and resident representatives present. There was evidence of transparent discussion and exchange of information.

In addition to the clinical and safety benefits evidenced there was also evidence that residents quality of life was enhanced by the review process. The inspector saw and the provider confirmed that further to completed audits an information session was facilitated in the centre by a local Citizens Information Officer and residents voting status had been established and a register maintained. The activities coordinator acted as an advocate for residents and records seen indicated that the role and function had been explained and discussed with each resident. The inspector recommended to the provider that training would benefit the initiative and support and safeguard staff undertaking an advocacy function.

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

*Each residents wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each residents assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.*

**Theme:**

Effective Care and Support

**Judgement:**

Non Compliant - Minor

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

No actions were required from the previous inspection.

**Findings:**

The inspector was satisfied that the needs of each resident were appropriately and adequately assessed by nursing staff who were competent and informed, worked closely with each relevant GP and other healthcare professionals and communicated effectively with care staff to ensure that those needs were met to a high standard.

A comprehensive assessment tool was used to assess and reassess each resident's abilities, needs, routines and preferences. Care plans were then devised based on the assessment finding and reviewed three monthly or more frequently as required. The inspector was satisfied that the care plans seen were personalised but evidence based, reflected the residents assessed needs and set out for staff appropriate care interventions. Care plans were supported by a suite of evidence based assessment tools that were also reviewed at a minimum three monthly. Care plans were signed as discussed with the resident or their representative as appropriate. The clinical dimension of the care plans was supplemented and complemented by an informative demographic and personal profile of each resident completed by the activities coordinator.

A record of each discussion held in relation to each residents care and welfare was maintained by the person in charge in addition to the daily nursing narrative record. Records seen and staff spoken with confirmed that residents had ready access to other healthcare professionals including speech and language therapy, dietetics, tissue viability, psychiatry of old age, physiotherapy, chiropody, optical review and podiatry. The inspector also saw that residents were facilitated to attend local day care services.

Records were maintained of the information exchanged when a resident was transferred to and readmitted from another healthcare facility.

There was evidence of the administration of influenza vaccination and blood profiling; residents' vital signs, weight and Malnutrition Universal Screening Tool (MUST) score were monitored at a minimum monthly. Where issues of concern were noted there was evidence of referral and the implementation of nutritional care plans. Nutritional supplements were individually prescribed and formal procedures to monitor staff accountability and responsibility for their administration were in place.

The inspector saw documents that supported evidence based wound care including assessment of risk, the provision of pressure relieving equipment in line with that risk, anatomical wound charts, wound assessments, dressing plans and dated photographs that indicated wound healing.

There was an evidence based approach to falls prevention and management with evidence of interventions including falls alert stickers, low beds, movement alarm mats and hip protectors. Following each fall nursing staff were required to complete a "corrective action report" that effectively ensured that staff followed the falls management protocol. The person in charge reviewed falls individually and collectively and where any pattern was identified such as time or location a corrective action was

put in place to reduce the risk of further falls.

The use of bed rails was monitored on a quarterly basis by the person in charge and implemented following the completion of a nationally agreed risk balancing assessment tool in conjunction with clinical judgement.

Where a resident presented with specific needs staff spoken with and records reviewed indicated that staff monitored those needs, intervened and sought to secure an appropriate plan of care to support the residents care and welfare in consultation and agreement with the resident, the relevant GP, family members and other healthcare professionals.

Based on the records reviewed, the inspector was satisfied that on balance residents had access to timely and comprehensive medical review and treatment in line with their needs. However, the admission policy was not specific in relation to the time frame within which each resident was to be medically reviewed following admission.

### **Outcome 12: Safe and Suitable Premises**

*The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.*

**Theme:**

Effective Care and Support

**Judgement:**

Non Compliant - Moderate

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

No actions were required from the previous inspection.

**Findings:**

Sacre Coeur Nursing Home is located just on the outskirts of Tipperary Town and is within reasonable walking distance of the town centre. The premises was originally constructed in 1911 and functioned as a convalescence facility for military personnel. It has been family owned and managed as a nursing home since 1983. The original premises is two storey with a further two storey extension added in the early 2000s.

Resident accommodation is provided on both floors in both the old and new elements of the building. Eleven residents are accommodated on the ground floor in three single bedrooms none of which are en suite, two single bedrooms each with en suite toilet, wash-hand basin and assisted shower and two three-bedded bedrooms neither of which are en suite. The first floor is split level and accessed by means of a stairwell and a stairs chair-lift. Six residents are accommodated at the lower level in three twin-bedded rooms none of which are en suite. A bathroom with toilet, wash-hand basin and assisted shower is conveniently located to these three bedrooms. There is a turn in the stairwell

(also serviced by the stairs chair-lift) that leads to five further bedrooms, one single and four twin-bedded rooms none of which are en suite. A further bathroom with toilet, wash-hand basin and assisted shower is within easy access of these bedrooms.

Given that the premises was not purpose built deficits were identified at the time of the registration inspection in October 2011. These were;

- one twin-bedded room and one three-bedded room did not meet the room size criteria laid down by the National Quality Standards for Residential Care Settings for Older People in Ireland
- insufficient toilets were provided for the number of residents accommodated and availability was compounded by the location of the toilets
- inadequate sitting, dining and recreational space was provided
- bedrooms and services on the first floor were accessed only by means of the stairwell or the stairs chair lift.

The inspector saw that the provider had provided a spacious additional toilet on the ground floor conveniently located to the communal and dining rooms and readily accessed by residents.

The provider confirmed that they were committed to the implementation of the architectural plans for the extension of the premises and the provision of a passenger lift to address the limitations of the current premises.

Notwithstanding these limitations and the period nature of the premises the inspector saw that the centre was extremely well maintained, in excellent decorative order, visibly clean, homely and welcoming, adequately heated, lighted and ventilated.

A contract was in place for the preventative maintenance of equipment and facilities.

Thermostatic controls were in place for the heating system and the hot water system and were seen to be within the recommended temperatures; hot water at wash hand-basins tested by the inspector did not present a scald risk.

Shared bedrooms were adequately screened to promote privacy and adequate segregated storage space was provided; residents also had access to secure personal storage.

Only two bedrooms had en suite sanitary facilities but all bedrooms had a wash-hand basin.

Residents had access to secure external grounds that were attractively planted and maintained to a high standard; adequate and strategically located seating was available. Access and egress of the premises and grounds was controlled by electronic keypad. Access to service areas was restricted and they were tidy and free of any obvious hazards.

Residents had access to and were heard to utilise the staff call-bell system.

Residents and relatives had access to a suitable and separate private area for visiting if

they so wished.

Suitable staff facilities were available.

Adequate provision was made for nursing and administration duties.

Catering facilities were monitored by the relevant Environmental Health Officer and a recent inspection report (7 November 2013) was made available for inspection and stated that the inspection outcome was satisfactory.

There was only one CCTV camera in use and this was located at the main entrance gate on the main road.

### **Outcome 13: Complaints procedures**

*The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.*

**Theme:**

Person-centred care and support

**Judgement:**

Non Compliant - Minor

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

No actions were required from the previous inspection.

**Findings:**

The complaints policy was closely aligned to regulatory requirements, was presented in a user friendly format and prominently displayed in the main reception area. The policy clearly outlined each staff members' role and responsibilities in managing complaints and training records indicated that an information session was provided for staff in March 2013.

The inspector reviewed the complaints log from July 2013 to date and six complaints were recorded. The records seen were detailed and indicated that the centre was open in relation to receiving complaints, that complaints were listened to, investigated, meetings were convened as necessary with complainants and the centre was transparent and accountable in relation to its policies and practices. There was evidence of action taken to prevent reoccurrence, feedback to staff and confirmation of complainant satisfaction.

Complaints, their management and resolution were audited on a quarterly basis. However, the person in charge who was also the nominated complaints officer completed the audits and this was not compatible with the requirements of Article (39) (10) (a) and (b).

**Outcome 18: Suitable Staffing**

*There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.*

**Theme:**  
Workforce

**Judgement:**  
Compliant

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

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

**Findings:**

The provider reported a low turnover of staff with many of the staff having established service in the centre. The inspector reviewed a random sample of three staff files and there was evidence of a robust recruitment process. All of the files reviewed contained all of the documentation required by the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). There was evidence that the provider had satisfied itself as to the authenticity of references and that each person was fit to work at the designated centre. Records indicated that supernumerary induction training was provided.

At the time of inspection nine nurses were employed and evidence of their current registration with their regulatory body was in place.

Procedures were in place for the vetting of persons providing services to residents on a regular basis.

A planned and actual staff rota was maintained. Based on her observations and these inspection findings the inspector was satisfied that the numbers and skill-mix of staff were adequate to meet the needs of the residents and other factors such as the layout of the building. There was a clear organisational structure in place and staffing levels were augmented by the presence of the person in charge, the nominated registered provider or the operations manager. The person in charge was satisfied and these inspection findings indicated that the person in charge had adequate time and resources to exercise her responsibilities to a high standard.

Training records indicated that there was a strong commitment to the provision of education and training for staff and that the programme was closely aligned to the resident profile and policies and procedures within the centre. Training records indicated that the mandatory training requirements of staff were within the required timeframes. Other training completed since the last inspection included medication management, falls prevention and management, dysphagia, the management of incontinence, resident rights, consent and advocacy, care planning and cardiac first responder.

A formal staff appraisal system was operated. Regular staff meetings were convened and minutes reviewed demonstrated comprehensive discussion and actions taken on issues directly relevant to the quality and safety of services provided to residents.

## **Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

### **Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

#### ***Report Compiled by:***

Mary Moore  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



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

Centre name:	Sacré Coeur Nursing Home
Centre ID:	ORG-0000278
Date of inspection:	09/12/2013
Date of response:	03/01/2014

### Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

### Outcome 02: Contract for the Provision of Services

**Theme:** Leadership, Governance and Management

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

Contracts were not dated when signed therefore it was not possible to definitively state that they were agreed within one month of the residents admission.

**Action Required:**

Under Regulation 28 (1) you are required to: Agree a contract with each resident within one month of admission to the designated centre.

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

Going forward, all new contracts of care will be dated upon signature to clearly show when they were actually agreed.

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

**Proposed Timescale: 03/01/2014**

### **Outcome 06: Safeguarding and Safety**

**Theme: Safe Care and Support**

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

A policy on the prevention, detection and response to any alleged, reported or suspected abuse was in place but it did not provide an alternative reporting pathway for staff in the event of an allegation against a member of the management team.

**Action Required:**

Under Regulation 6 (1) (b) you are required to: Put in place a policy on and procedures for the prevention, detection and response to abuse.

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

The policy in question is currently being updated to provide for an alternative reporting pathway for staff in the event of an allegation of abuse against a member of the management team. This policy will be issued to all staff and staff training will take place by the end of January 2014.

**Proposed Timescale: 31/01/2014**

### **Outcome 08: Medication Management**

**Theme: Safe Care and Support**

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

There was a procedure in place for the quarterly review of each resident's medication regime. However, what was not evident was the action taken on foot of any recommendations to ensure that each resident benefited from their medication.

**Action Required:**

Under Regulation 33 (1) you are required to: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

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

We have amended our medication review procedures to ensure that any actions taken on foot of any recommendations are now clearly documented in the resident's records. Nursing staff will be specifically trained on this change in procedure by the end of January 2014.

**Proposed Timescale: 31/01/2014**

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

**Theme:** Effective Care and Support

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

The admission policy was not specific in relation to the time frame within which each resident was to be medically reviewed following admission.

**Action Required:**

Under Regulation 6 (3) (c) you are required to: Provide appropriate medical care by a medical practitioner of the residents choice or acceptable to the residents.

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

The admissions policy is currently being updated and will specify a timeframe for medical review following admission. The policy will be issued to staff and staff training will take place by the end of January 2014.

**Proposed Timescale: 31/01/2014**

### **Outcome 12: Safe and Suitable Premises**

**Theme:** Effective Care and Support

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

One twin-bedded room and one three-bedded room did not meet the room size criteria laid down by the National Quality Standards for Residential Care Settings for Older People in Ireland.

Inadequate sitting, dining and recreational space was provided.

Bedrooms and services on the first floor were accessed by means of the stairwell or the stairs chair lift.

The sluice room was dual purpose and not conducive to effective infection prevention and control as it was also utilised by environmental hygiene staff.

**Action Required:**

Under Regulation 19 (3) (a) you are required to: Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.

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

We are currently progressing a renovation and upgrading project for the nursing home building which will address the requirements for the Regulations in full.

**Proposed Timescale: 30/06/2015**

**Outcome 13: Complaints procedures**

**Theme:** Person-centred care and support

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

The person in charge who was also the nominated complaints officer completed the audits of complaints and this was not compatible with the requirements of Article (39) (10) (a) and (b).

**Action Required:**

Under Regulation 39 (10) you are required to: Make a person available, independent to the person nominated in Regulation 39(5), to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 39(5) maintains the records specified under Regulation 39(7).

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

We have amended our audit procedure to provide that the nursing home complaints procedures will be audited by the Registered Provider nominee rather than the Person in Charge.

**Proposed Timescale: 03/01/2014**