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:	19 June 2025
Centre ID:	OSV-0000157
Fieldwork ID:	MON-0042721

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 85 residents, both male and female over the age of 65, with low to maximum dependency levels. Residents are accommodated in 85 single bedrooms, all with full 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, an assistant director of nursing and clinical nurse managers. 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:	84

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
Thursday 19 June 2025	07:45hrs to 16:40hrs	Maureen Kennedy	Lead
Thursday 19 June 2025	07:45hrs to 16:40hrs	Niamh Moore	Support

What residents told us and what inspectors observed

On the day of inspection, the inspectors met with many residents and spoke with visitors to gain insight into their experience of living in Sacred Heart Residence. All residents spoken with were complimentary in their feedback and expressed satisfaction about the standard of care provided. Residents reported that the service was good and that they were happy in the centre. Visitors told inspectors that the staff are "absolutely wonderful", their family member is "very happy here".

There were 84 residents living in the centre with a resident admission expected on the day of the inspection. The premises consists of five floors in total, with lifts and stairs to facilitate movement between these areas. There is a laundry, kitchen, offices and staff areas including changing rooms in the basement. The ground floor has many communal areas including a large dining room, an auditorium, a shop and tea-rooms which may be used for family gatherings and special occasions. Residents' accommodation is within five units referred to as Mountain View, Dom Marmion, John Vianney, St Therese's and St Joseph's set out over the first, second and third floors. These units had a homely feel with dining and sitting rooms available on each unit. Residents' bedroom accommodation is provided in single rooms, all with en-suite facilities.

The bedrooms viewed by inspectors were homely, clean, and well laid out with sufficient storage space for belongings. Bedrooms were personalised with items of furniture and family photographs and personal items, to help residents feel more at home. On the first floor, the foyer with access to the balcony was a light-filled area containing nice seating and a wide variety of greenery and plant pots, which were attended to by residents who enjoyed gardening. The premises was clean and in general well-maintained. There was evidence of ongoing maintenance with a team of maintenance personnel responding to maintenance requests during this inspection.

Residents had access to advocacy services. Residents had opportunities to meet with visitors and there were numerous private spaces throughout the building for these visits to occur. A range of activities were available to residents, seven days a week, which included gentle exercise classes, day trips, creative art and crafts including ceramics and painting, brain games, bridge club and bingo. Visitors spoken with acknowledged to inspectors the good group activities in place, however they said they would like to see more one-to-one activities available, including access to the garden in times of good weather.

The atmosphere in Sacred Hearts' spacious residence was tranquil and unhurried with wide corridors and ample communal space supporting the free movement of residents. The inspectors spent time observing the environment and interactions between residents and staff. All interactions observed were person-centred and

courteous. Staff were responsive and attentive while attending to residents' requests and needs on the day of inspection.

The inspectors observed the lunch time meal experience. Residents could choose to dine in the main dining room on the ground floor, in any of the smaller dining rooms on each unit, or in their bedrooms. In each of the dining rooms, the tables were set in a homely manner with menus on display and condiments and drinks within easy reach of residents, enabling them to maintain their independence. There was a choice of main meal on the day of roast pork or lamb korma and rice. Mealtime was observed to be a relaxed and sociable occasion, with residents and staff chatting together. Staff spoken with had good knowledge of residents' dietary needs to include likes, dislikes and relevant modified diets. Staff were observed offering gentle encouragement and assistance to residents. Residents reported always being afforded choice and provided with an alternative meal should they not like what was on the menu. The meals provided appeared appetising and were served hot. Feedback received from residents on the day of the inspection was that they enjoyed the meals on offer, with one resident stating the food was "gorgeous" and another resident telling the inspectors they particularly liked the soup.

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 impact on the quality and safety of the service being delivered.

Capacity and capability

Overall, the inspectors found that residents in the centre benefited from a well-run centre with good leadership and good governance and management arrangements in place. It was evident that the centre's management and staff focused on providing quality service to residents and promoting their well-being. Documentation requested for the inspection was available and provided in a timely manner. However, there were gaps in some residents' care records as outlined under Regulation 21: Records.

Little Sisters of the Poor is the registered provider for Sacred Heart Residence. There were clear roles and responsibilities outlined, with oversight provided by the person in charge, who was supported by an assistant director of nursing and two clinical nurse managers, a team of nurses and healthcare support staff.

There was a schedule of regular team meetings in place including clinical governance, management and staff meetings. Agendas were comprehensive comprising of health and safety, risk management, accidents or incidents, complaints or premises issues to name a few. Minutes of these meetings were provided to the inspectors. There was an annual review of the centre and a quality improvement plan in place. The residents' opinions and their views were taken into

account when developing this annual review. The management team had developed audits that identified where improvements were required. They used these audits to implement improvement plans and drive quality care.

There appeared to be sufficient staff on duty on the day of the inspection to support the needs of the residents. The staff were visible within the nursing home tending to residents' needs in a respectful manner. Staff had the required skills, competencies and experience to fulfil their roles and responsibilities. The complaints policy and procedure was reviewed. Complaints were managed as per the policy and at the time of inspection there was one open complaint in progress.

Regulation 16: Training and staff development

Staff had access to training appropriate to their role. There was an ongoing schedule of training in place to ensure all staff had relevant and up-to-date training to enable them to perform their respective roles. Staff were appropriately supervised and supported.

Judgment: Compliant

Regulation 19: Directory of residents

The registered provider had a directory of residents which met the regulatory requirements and was made available when requested.

Judgment: Compliant

Regulation 21: Records

Some records, required to be maintained in respect of Schedule 3 of the regulations, were not appropriately completed. For example:

- Records of specialist treatment and nursing care provided to residents were not maintained in line with the requirements of Schedule 3(4)(b). For example, records of repositioning charts for residents at high risk of impaired skin integrity, records of food and fluid intake and bedrail and lapbelt release

documentation were not consistently maintained in line with the residents' care plans.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. Members of the management team were aware of their lines of authority and accountability and demonstrated a clear understanding of their roles and responsibilities. They worked well together, supporting each other through a well-established and maintained system of communication. There were clear systems in place for the oversight and monitoring of care and services provided for residents.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose was within date, available throughout the centre and contained the prescribed information as set out in Schedule 1 of the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was on display in a prominent position within the centre. The complaints policy and procedure identified the person to deal with the complaints and outlined the complaints process.

Judgment: Compliant

Quality and safety

Overall, the inspectors were assured that residents were supported and encouraged to have a good quality of life in the centre and that their healthcare needs were well met. Residents and visitors voiced their satisfaction with the care provided in the centre. However, further improvements were required in relation to restrictive practices and end-of-life care which will be discussed under their respective regulations.

Residents had access to a general practitioner (GP) who attended the centre regularly. Access to specialised services such as palliative care were available through a referral system. Residents' records showed that residents also had access to services such as tissue viability, speech and language therapy, dietitians and physiotherapy. Community services such as chiropody were also available.

Staff had access to relevant training on responsive behaviours (how persons with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). A policy on caring for residents with these behaviours was also available to staff. Care plans on responsive behaviours detailed triggers and de-escalation measures to relax and reassure residents. From a sample reviewed, inspectors found incident documentation which evidenced that these measures were trialled with residents. In addition, on the day of the inspection, inspectors observed staff providing person-centred care and support to residents who experienced responsive behaviours.

The registered provider had a policy on Restraint Use and Restrictive Practice effective from September 2024. There was evidence that when restraint such as bedrails were used, an assessment and a care plan was completed to ensure it was the least restrictive measure in place. However, inspectors found the policy had not been fully implemented for all other types of restraint, this is further discussed under Regulation 5: Individual assessments and care plans.

Inspectors saw records of communication with families relating to changes to care provision. A sample of residents' records such as assessments and care plans were reviewed on the day of inspection. Pre-assessments were carried out prior to the residents' admission to the designated centre to ensure the registered provider could meet the residents' needs. Documents outlined that comprehensive assessments and care plans were carried out within 48 hours of admission to the centre. Validated assessment tools were used to guide the development of care plans. The inspector saw care plans were updated as required and at minimum of four monthly intervals in line with the regulations. However, improvements were required to ensure that interventions detailed in the individualised care plans were being implemented in practice, as further detailed under Regulation 5.

The registered provider had a safeguarding policy, and a policy on the management of residents' personal possessions which provided staff with support and guidance in recognising and responding to allegations of abuse. Inspectors saw evidence that where required, appropriate referrals to external agencies such as the safeguarding and protection team were completed.

Residents had documented instructions regarding resuscitation or transfer to the acute setting in the event of a sudden health decline. For residents who were approaching comfort or palliative care, there was evidence of frequent engagement with the GP and palliative care team on this matter. However, further oversight of the planning and decision-making about a person's end-of-life care was required to ensure care was based on individual's expressed wishes. This is detailed under Regulation 13: End of life care.

Inspectors found that the premises was well-laid out to meet the needs of the residents, and in accordance with the statement of purpose. The centre was clean and overall well-maintained by a team of maintenance and housekeeping staff. Infection prevention and control measures were in place, such as multidrug-resistant organism (MDRO) surveillance and antibiotic usage.

Regulation 13: End of life

Not all end-of-life care plans addressed the needs of the residents in a holistic manner. In a sample review, two end-of-life care plans outlined residents' wishes for pain and symptom management with no other detail provided. This meant that where a resident was approaching the end of their life, staff may not be aware of the individual preferences relating to their emotional, social, psychological and spiritual needs.

Judgment: Substantially compliant

Regulation 17: Premises

The premises was appropriate to the needs of the residents and promoted their privacy and comfort.

Judgment: Compliant

Regulation 27: Infection control

Infection prevention and control training was up to-date. The registered provider had adequate resources available to ensure safe infection prevention and control practices were effectively implemented. Housekeeping staff spoken with explained

the communication channels to ensure they were informed of any infection prevention and control issues and outbreaks.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Inspectors saw there were gaps in the residents' care records as outlined under Regulation 21: Records which did not provide assurance that care plans were always based on assessments to inform care based on current needs and that interventions outlined in residents' care plans were consistently implemented in practice. For example:

- While restrictive practices in use were documented in care plans, assessments were not completed every four months on all restraints to evidence their use. For example, sensor alarms in use on the day of the inspection had a yearly risk assessment in place and lap belts in use did not have any assessments.
- Care plans that prescribed the required interventions to support residents' care such as regular repositioning, monitoring of nutritional intake were not consistently implemented in practice.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Notwithstanding that staff had received training in responsive behaviours and there was a policy in place, further actions were required to ensure that both the local and national policy were implemented in practice. For example:

- The sensor alarm assessment was separate to the electronic system in place and some staff spoken with were not aware of this assessment. Therefore assurances were not received that these restrictive practices were used in line with the residents' current assessed needs and for the least time required.
- Restrictive practices such as sensor alarms were not recorded on the registered provider's restraint register. This was not in line with the designated centre's policy on the management of restrictive practice.

Judgment: Substantially compliant

Regulation 8: Protection

There were systems in place to safeguard residents. All staff had completed online safeguarding training and those spoken with detailed their understanding of putting this training into practice. The registered provider was not a pension-agent for any residents.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

The person in charge ensured that where a resident was discharged from the designated centre, it was done in a planned and safe manner.

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 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: End of life	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 27: Infection control	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant

Compliance Plan for Sacred Heart Residence OSV-0000157

Inspection ID: MON-0042721

Date of inspection: 19/06/2025

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 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
To ensure full compliance with Schedule 3 requirements, the following measures have been implemented:
• Specialist Treatment and Care Records: All records relating to specialist treatment and nursing care are to be completed accurately and consistently in accordance with Schedule 3.
• Skin Integrity Management: Residents identified as being at risk of impaired skin integrity will have repositioning booklets in place to document and guide care interventions.
• Lap Belt Monitoring: For residents using a lap belt, a lap belt fastening and release monitoring booklet will be maintained to ensure safety and proper usage.
• Food and Fluid Documentation:
o All food and fluid intake will be recorded in Med e care Point-of-Care.
o For residents nearing end of life, additional paper-based records will be maintained to ensure comprehensive monitoring.
• Bedrail Documentation: Use of bedrails will be documented within the Med e care system to ensure safety and regulatory compliance.
• Daily Documentation Checklist: A daily checklist has been introduced for staff nurses to ensure that all required documentation is completed consistently.
• Ongoing Audits and Supervision:
o Regular audits will be conducted to assess documentation practices and identify any areas of non-compliance.
o Supervision and support will be provided to staff as needed, addressing gaps through education and performance feedback.

Regulation 13: End of life	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: End of life:
To ensure the holistic needs of residents at end of life are fully met, the implementation of updated and more robust advanced healthcare directives is currently underway. These enhanced, person-centred directives will address not only pain and symptom management but also the emotional, social, psychological, and spiritual dimensions of care.
All relevant information will be accurately documented within each resident's end-of-life care plan and integrated into the ongoing audit process to ensure consistency, quality, and compliance with best practice standards.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
In response to identified gaps in residents' care records, a structured process for conducting four-monthly assessments of sensor alarm and lap belt use has been fully implemented. These assessments serve as the foundation for updating individual restraint care plans, ensuring that all required interventions are clearly documented and tailored to the resident's needs.
To strengthen this process:
• The admission care plan checklist has been updated to include mandatory assessments for sensor alarm and lap belt use.
• These assessments will be incorporated into the next scheduled care plan audit to monitor compliance and identify areas for improvement.
For residents requiring specific interventions, such as:
• Regular repositioning
• Nutritional intake monitoring
Documentation is consistently maintained using designated monitoring booklets. The staff nurse is accountable for ensuring that these records are completed accurately and consistently, thereby supporting the provision of safe, effective, and person-centred care.

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:

To ensure full implementation of both local and national policies, sensor alarm and lap belt assessments are now conducted every four months within the Medecare system. These assessments are used to update individual restraint care plans, ensuring that all interventions are clearly documented and reflect the resident's current needs.

Key actions include:

• Staff Awareness: All staff have been informed of the revised assessment process during handover sessions, ensuring consistent understanding and implementation across the team.

• Restrictive Practices Register: The use of sensor alarms is now accurately recorded in the restrictive practices register, and this information will be included in quarterly notifications submitted to HIQA.

• Audits and Compliance Monitoring:

o Regular audits will be carried out to monitor compliance with the four-monthly assessment schedule and documentation standards.

o Any gaps or inconsistencies identified will be addressed promptly through supervision and targeted staff education, ensuring ongoing adherence to policy requirements.

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 13(1)(a)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that appropriate care and comfort, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned are provided.	Substantially Compliant	Yellow	22/08/2025
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.	Substantially Compliant	Yellow	22/07/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4	Substantially Compliant	Yellow	22/07/2025

	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.			
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	22/07/2025