Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Holy Family Residence
Centre ID:	ORG-0000050
Centre address:	Roebuck Road, Dublin 14.
Telephone number:	01 283 2455
Email address:	lspholyfamily@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Little Sisters of the Poor
Provider Nominee:	Christine Devlin
Person in charge:	Kathleen McMahon
Lead inspector:	Mary O'Donnell
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	45
Number of vacancies on the date of inspection:	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 judgments 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 compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
06 November 2013 09:00	06 November 2013 16:00

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

Outcome 11: Health and Social Care Needs
Outcome 14: End of Life Care
Outcome 15: Food and Nutrition

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on two specific outcomes, End of Life Care and Food and Nutrition. In preparation for this thematic inspection providers attended an information seminar, received evidence-based guidance and undertook a self-assessment in relation to both outcomes. The inspector reviewed policies and analysed surveys which relatives submitted to the Authority prior to the inspection. The inspector met residents, religious sisters and staff and observed practice on inspection. Documents were also reviewed such as training records and care plans. The assistant director of nursing who completed the provider self-assessment tool had judged that the centre was compliant in relation to both outcomes.

The inspector found substantial compliance in the area of food and nutrition and a minor non-compliance in the area of end of life care 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.

Services had developed to meet the diverse nutritional needs of residents, especially those residents with eating and swallowing impairments. A nutritional committee had been set up since the previous inspection and robust communication systems between residents, clinical and catering staff had been put in place. Other service improvements were progressed or completed. Controls were in place to manage and monitor risks and procedures were in place to ensure that staff were suitably trained and supported.

The quality of end-of-life care was good and residents were supported in their religious and spiritual practices. Residents lived a dignified life, they had single rooms

and daily life in the centre maximised the residents' capacity to exercise choice and personal autonomy. However, residents were not provided with a timely opportunity to express their preferred wishes for end-of-life care. Families were supported and provided with the use of a visitors' suite or reclining chairs if they wished to stay with an ill or dying resident.

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

Findings:
The inspector focused on end of life and nutritional assessment and found that assessments were not updated to inform care plan reviews. This is discussed in more detail under Outcome 14.

Some social assessments lacked key information such as the names of a resident's children and the resident's favourite foods and beverages.

Outcome 14: End of Life Care
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

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 inspector found that there were care practices and facilities in place so that residents received end-of-life care in a way that met their individual needs and wishes. Care practices upheld the dignity and respected the autonomy of residents. However, the policy needed to be amended to reflect all the relevant aspects which pertain to end-of-life care.

The end-of-life policy was last reviewed in March 2013. The policy was clear but needed to be expanded to cover all the relevant areas, such as the laying out of a deceased resident and release of the deceased resident to the mortuary. These issue was identified in the self-assessment questionnaire. The religious sisters were a strong presence in the centre and had an intimate knowledge of all the residents their family members and staff who cared of residents. Staff interviewed were fully aware of the care of the dying and procedures relating to the care of the body once a resident had died. However, this was communicated verbally and not included in the policy.

There was a system in place to ensure that staff read and understood the policy. Team communication and supervision was good and 27 staff had recently attended training to support them to plan and provide appropriate end-of-life care. Staff told the inspector that the training made them aware of the need to proactively involve residents in planning for future health events and end-of-life care at an earlier stage. Current practice was to put an end of life care plan in place when a resident's health deteriorated and death appeared to be close.

The inspector examined six residents' files and found that two residents had an end-of-life care plan. There was evidence that the general practitioner (GP), nursing staff and family were involved in drawing up the care plans and in one case the resident was able to voice her wishes and these were documented and respected. Staff stated that care plans were reviewed quarterly or if there was a change in a resident's condition. All the care plans viewed were updated within the previous three months. However, residents were not routinely reassessed to inform the care plan review and some assessments were dated 2011.

Residents spoke with the inspector about their wishes and preferences for end-of-life care or in the event that their health deteriorated. The majority wished to remain in the centre. They confirmed that this information had not been sought nor shared with staff, but they all confident that the matter would be handled appropriately when the time came. Some residents felt the decision was largely out of their hands. "An ambulance would be called if someone collapsed; it's what happens around here". "The medics make the decisions about what happens to me". "It will all be taken care of whenever it happens".

Information was held on file in the administration office about the funeral and interment wishes of the 48 residents. The person in charge explained that this information was taken when each resident was admitted to the centre. The inspector noted that the fields for decisions and wishes relating to transfer to acute care or resuscitation status

were left blank. The self-assessment indicated that 25 of the 28 residents who died in the preceding 24 months had died in the centre, and three residents died in hospital.

Care staff told the inspector about how they supported relatives by providing refreshments and maintaining a peaceful environment. They provided examples of practical care for a dying resident such as providing mouth care and changing their position and speaking with the dying resident. They explained that they had covered aspects of the carer's role in end of life care when they did the Further Education and Training Awards Council (FETAC) level five Care Skills programme. Records showed that all but six care staff had a FETAC qualification. Nurses interviewed had a wide range of nursing experience but they did not have specific training for end-of-life care such as, the use of a syringe driver, spiritual care, and palliative care.

Residents and relatives commented favourably on the staff in the unit. They were especially complimentary about the relationships that developed between residents and staff and how staff strived to meet their needs and keep everyday life normal. One resident commented that the "Reverend Mother must have been granted divine intervention when she hired staff... they were all so marvellous, good humoured and caring".

Residents could retain the services of their own GP. The vast majority of residents were under the care of a GP who visited the centre twice weekly and also provided an out-of-hours and weekend service. Residents expressed satisfaction with this service.

The centre had access to a consultant-led palliative care service. There was no resident receiving the services of the palliative care team at the time of inspection. Residents also had access to specialist gerontology services and psychiatry of later life services. Records showed that residents could attend these services at St Vincent's Hospital and the services were provided to residents in the centre when required.

All residents in the centre had single rooms. There was a mobile with religious symbols, holy water, candles and a crucifix to use when a resident was dying, if this was in-keeping with the expressed wishes of the resident and family. Family and friends were facilitated to be with the resident when they were dying. Relatives who returned completed questionnaires described the end-of-life care provided by staff as very good or excellent. This included pain and symptom management, meeting spiritual and religious needs and time spent with the resident as well as family support provided.

Staff described how they responded if a resident died suddenly and the inspector found that the situation was managed in a dignified manner, and that relatives had been appropriately informed and supported. The inspector saw from records of deceased residents and relatives comments that family were usually present at the time of death and felt supported following the event. Religious sisters also spent time with very ill or dying residents so these residents were never alone.

There was a written procedure for staff to follow after the death of a resident in relation to the verification and notification of death. Relatives were given verbal information about registering the death and access to bereavement support. The person in charge discussed plans to develop leaflets to improve this aspect of the service.

Residents and staff were appropriately informed and supported following the death of a resident. The death was announcement at daily Mass. Staff and residents confirmed that they had availed of the opportunity to visit a deceased resident in the chapel and participate the removal and attend the funeral if this was their wish. Staff were texted to inform them when a resident had died. Residents told the inspector about the remembrance service which was held in November where a candle was lit for each resident who had died. The person in charge told the inspector that they issued an invitation to families to participate in this annual event and also in the Month's Mind Mass. Personal possessions were formally documented and there was a protocol for the return of personal possessions. The inspector saw that following the death of a resident family were invited to use a suitcase to collect personal possessions.

The centre was run by a religious order of nuns and a Christian ethos was very evident. The statement of purpose indicated that people of all religious persuasions and none were admitted. On the day of inspection, all the residents were Roman Catholic. Residents and relatives were satisfied that their religious and cultural practices were facilitated. There was a Chaplin in residence and religious ministers visited frequently to minister to residents. Residents told the inspector that they were supported to continue their religious and spiritual practices. The chapel could be accessed from the first and second floor and there was an oratory on the third floor. Daily Mass was broadcasted from the chapel to the televisions and day rooms. The inspector noted that those who did not wish to attend had their wishes respected.

Residents told the inspector that they enjoyed a good quality of life. They were facilitated to maintain contact with their friends and their families. The layout and furnishings in the centre was very homely and there were numerous sitting rooms and alcoves for residents to use. Some residents spoke about the new friendships they had developed since they came to live in the centre. There was a sense that residents led purposeful lives. One man was taking his car for an NCT. A staff member was in the shop assisting a lady with complex health issues to select a birthday card for her nephew. Residents attended daily activities in the centre and some residents who liked to read were pleased with the variety of large print books available in the centre's library. Residents said they had enjoyed being outside in the garden during the summer. Residents could go outside independently and those who were less able confirmed that staff provided timely assistance when required.

Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

Judgement:
Compliant

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

Findings:
Each resident was provided with food and drink at times and in quantities adequate for his/her needs. Food was properly prepared, cooked and served, and was wholesome and nutritious. Assistance was offered to residents in a discreet and sensitive manner.

The inspector found that residents received a nutritious and varied diet which offered choice. The nutrition and hydration policy was reviewed in March 2013 and there was a system in place to ensure that staff understood and implemented the policy. Staff also had training to support them in monitoring the nutritional welfare of residents and there were systems in place to intervene when a resident was at risk of malnutrition or dehydration.

Residents had a nutritional assessment on admission and three monthly thereafter. A validated screening tool was used to identify anyone who was malnourished or at risk of malnutrition. Nurses were trained and used the tool appropriately. The food taken was recorded daily and residents were routinely weighed on a monthly basis. Those who were at risk of malnutrition were weighed weekly and monitored using food and fluid intake charts. Medical reviews and referrals to dietetic services were also arranged. Some residents had on-site or out patient access to speech and language therapy (SALT) and dietetic services through acute hospitals and a pharmaceutical company also provided SALT and dietetic services to residents who required the service. Records showed that residents had timely access to these services. There were no residents having nutrition through a tube at the time of inspection. There were six residents with diabetes and the inspector found that these residents were appropriately monitored and linked with diabetic clinics. The centre did not use the services of an occupational therapist and the physiotherapist, who attended the centre twice weekly assessed residents who required supportive seating or specialist equipment. Residents were very satisfied with the physiotherapy service on offer.

The self-assessment questionnaire stated that all peripatetic services met the residents' needs well or very well. The residents concurred with this except for a recent in-house dental service which they described as "hopeless" and "appalling". Residents were dissatisfied with the quality of the dental assessments and some residents complained that the dentures they were provided with were too uncomfortable to wear. One resident was now wearing her old dentures and another attended her own dentist to have her plate "properly fitted". The person in charge said she will follow up on this with the private firm who offered the service.

Good quality nutritional care plans were in place which reflected the individual needs and specialist advice. Food and fluid intake records were appropriately maintained. Food fortification was used as a first line measure and six residents had food which was fortified using butter, and cream. Eleven (23%) of residents were taking nutritional supplements. Medication records showed that supplements were prescribed and appropriately administered. One resident used assistive cutlery and another resident had been provided with a special cup on the advice of the SALT to eliminate the need for thickened fluids and promote independence.

Meals were served at a time that suited residents. Residents told the inspector that they enjoyed their meals and that they were provided with a choice for their three meals. The inspector saw that residents had breakfast in their rooms and later joined residents for dinner in the central dining room. The menu displayed at the door offered a choice of Irish stew or braised sausages and this was served with two vegetables and creamed or jacket potatoes. Alternative foods were also provided and some residents took ham instead of the items listed on the menu. Mushroom soup was served in tureens on individual tables.

The inspector noted two residents chose to dine in their bedrooms and some residents dined in the small dining rooms on the upper floors. These dining rooms were intimate and homely and suited residents who preferred to dine in a peaceful environment. Carpets, curtains, table cloths and linen napkins had a matching colour scheme. Tables were dressed attractively with individual place settings. Some dining rooms had a china cabinet and residents used china cups and saucers. Sufficient staff were present in each floor to supervise and provide appropriate assistance.

The majority of residents dined in the main dining room on the ground floor. This was a large bright room and meal times there were found to be a pleasant, sociable occasion. People who attended day care took their meals in the dining room and tables accommodated small groups which facilitated social interaction. Each table was dressed nicely with table cloths, flowers, linen napkins, individual place settings, condiments and jugs of water. Residents who needed their food pureed or chopped had it presented in appetising individual portions on their plate. Staff members said that they had training on nutrition and helping people with swallowing difficulties and training records confirmed this. All staff had first aid training and described how to respond if a resident had a choking episode. Care plans stressed the importance of pacing a meal appropriately and describing the food for residents who had sensory deficit or were cognitively impaired. The inspector observed friendly interaction between staff and residents. Staff described the content of pureed or minced food when serving the resident and they sat with residents who required assistance with meals.

There was clear, documented system of communication between nursing and catering staff regarding residents' nutritional needs. Since the previous inspection a nutrition committee had been formed which comprised a nurse representative from each floor, the assistant director of nursing and the head chef. The four weekly menus had been submitted for dietetic review and the committee were awaiting feedback. Communication between nursing and catering staff had improved since the nurse representative communicated directly with the head chef regarding the dietary needs of residents on each floor. Dietary fibre was increased with fresh prune juice offered with breakfast cereals and bowls of fresh fruit were placed on each table in the dining rooms.

There were a number of residents with specialist dietary requirements such as diabetic or high calorie diets. The chef was well informed about each resident's needs and residents' likes and dislikes. The chef showed the inspector the list of resident's dietary needs and food consistency. Food stocks were checked and found to be adequate. The inspector saw that the chef and the catering team served the meals in the dining room and spoke with residents to ask their views on the food. Menus displayed in the dining room were clearly legible. Residents and staff told the inspector that each day a staff

member asked them what they would like to have for lunch. The inspector saw that extra options were always available apart from the menu. There was also a choice of desserts provided. The inspector read the choices for the tea time meal and found that there was a variety of foods available. Residents were provided with home baking daily. The inspector also saw residents and visitors using the tearooms to have afternoon tea.

Residents were satisfied with the times that meals were served and they felt that management listened to their views responded accordingly. The records of residents meeting with managements showed that issues about food were often raised. The introduction of individual gravy and sauce boats for each table in the dining room, changes to the sequencing of serving meals and the saltiness of the soup were all issues raised which were successfully resolved.

The inspector saw residents being offered drinks, tea and snacks throughout the day. Jugs of water were provided in common areas. Staff explained that foods such as yogurts and milk puddings were left in a fridge in the kitchen so resident had access to snacks during the night. Residents told inspectors that they would be provided with a meal or a snack at any time.

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:

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Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	Holy Family Residence
Centre ID:	ORG-0000050
Date of inspection:	06/11/2013
Date of response:	14/11/2013

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 11: Health and Social Care Needs

Theme: Effective Care and Support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Assessments were not updated to inform the three monthly revision of care plans.

Action Required:
Under Regulation 8 (1) you are required to: Set out each resident's needs in an individual care plan developed and agreed with the resident.

Please state the actions you have taken or are planning to take:
1. Update Assessment of Needs for every Resident
Proposed Timescale 31st December 2013

2. Update Social Assessments with families
Proposed Timescale 28th February 2014

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

Proposed Timescale: 28/02/2014

Outcome 14: End of Life Care
Theme: Person-centred care and support **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** Residents end-of-life care preferences were not assessed and recorded. **Action Required:** Under Regulation 14 (2) (d) you are required to: Identify and facilitate each residents choice as to the place of death, including the option of a single room or returning home. **Please state the actions you have taken or are planning to take:** 1. Update Admission Records to include specific requests of Residents in the event of illness or death.
Proposed Timescale: 30/04/2014
Theme: Person-centred care and support **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** The end-of-life care policy did not include aspects of care such as, the laying out of a deceased resident's body or the how personal possessions were returned. **Action Required:** Under Regulation 14 (1) you are required to: Put in place written operational policies and protocols for end of life care. **Please state the actions you have taken or are planning to take:** 1. End of Life Policy to be updated to include the laying out of a deceased resident’s body and how their personal possession are returned or disposed of.
Proposed Timescale: 31/12/2013