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:	Mount Carmel Nursing Home
Centre ID:	ORG-0000734
Centre address:	Abbey Street, Roscrea, Tipperary, Tipperary.
Telephone number:	0505 21146
Email address:	annkeevey@mountcarmelnursinghome.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Sisters of St. Marie Madeleine Postel
Provider Nominee:	Sr Marie Keegan
Person in charge:	Anne Keevey
Lead inspector:	Sheila Doyle
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	29
Number of vacancies on the date of inspection:	0

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:
16 October 2013 09:00	16 October 2013 14:30

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

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, relatives, staff and observed practice on inspection. Documents were also reviewed such as training records and care plans. The director of nursing who completed the provider self-assessment tool had judged that the centre was compliant in relation to both outcomes.

The inspector concurred with this and found that in the areas of food and nutrition and end-of-life care, the centre was in substantial compliance with the requirements of 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 nutritional needs of residents were met and residents' end-of-life needs were well managed with a high standard of nursing care being provided at this stage of life. There was ample evidence of good practice under both outcomes and no actions were required from this inspection.

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 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:
Compliant

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

Findings:
The inspector was satisfied that caring for a resident at end of life was regarded as an integral part of the care service provided in centre. 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. The inspector also saw that residents' dignity and autonomy were respected.

The end-of-life policy, reviewed in November 2012, was comprehensive, evidence-based and the inspector was satisfied that it guided practice. There was a system in place to ensure that staff read and understood the policy. Staff members spoken with confirmed this and were knowledgeable about its contents.

The inspector saw that improvements had recently been undertaken as regards the use of appropriate care plan documentation which was computerised. A comprehensive end-of-life section was in place with specific prompts to guide staff. Another document was also being introduced which outlined residents wishes regarding specific areas such as who would look after finances or who knew about the preferred funeral arrangements. The inspector read some completed copies and saw that in some cases residents and relatives outlined very specific instructions and preferences such as their wishes regarding transfer to general hospitals and funeral arrangements.

All residents were cared for in single rooms. Although it had not happened to date, staff confirmed that should a resident so wish they would be supported to return home if possible. The inspector reviewed questionnaires returned by the relatives of residents who had died in the centre. Relatives stated that they were very satisfied with the care which had been provided before, during and after the death of their loved one. They stated they were made feel welcome and were facilitated to stay overnight and be with the resident during their last days. All relatives stated that the service could not be improved upon.

Staff discussed with the inspector other initiatives that were underway within the centre. The person in charge was currently compiling an information folder for relatives including information regarding funding and grants, registering deaths etc. The inspector also saw that bereavement leaflets and other resources were available to relatives, residents and staff.

The centre had access to a consultant led palliative care service. The person in charge stated that the centre maintained strong links with the local palliative care team. The inspector saw that there was good access to this service when required both for advice and support.

Religious and cultural practices were facilitated to a high standard. Religious ministers visited frequently. The policy provided guidance for staff on spiritual and end-of-life care for people from a diverse range of religions. Residents told the inspector that they were supported to continue with their religious and spiritual practices. Many residents enjoyed daily mass.

There was a written procedure for staff to follow after the death of a resident in relation to the care of the deceased person's body and the verification and notification of death. 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. Staff had received training regarding end-of-life care and staff spoken with were knowledgeable. Additional training was planned for this year. Many spoke of being with the resident, never allowing a resident to be left alone. A checklist had been introduced to ensure that all necessary procedures were followed including notifying family members, the GP and the coroner. The person in charge audited the documentation to ensure completeness and compliance with the requirements of the policy.

Residents and staff were appropriately informed and supported following the death of a resident. Residents and staff told the inspector about the remembrance mass each where each resident who had died in the previous 12 months was remembered. Staff told the inspector that they issued an invitation to families to participate in this annual event.

Staff and residents confirmed that they had availed of the opportunity to say farewell to and participate in the prayer service at the removal. Staff also told the inspector that as far as possible several staff members attended each funeral to pay their last respects.

There was a procedure in place for the return of possessions. A specific bag was set aside for this and relatives were given adequate time to return to the centre to gather any belongings they wished to keep.

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:
No actions were required from the previous inspection.

Findings:
The inspector was satisfied that each resident was provided with food and drinks 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.

There was a centre-specific policy in place for the monitoring and documentation of nutritional intake. This provided detailed guidance to staff. Staff members spoken with were knowledgeable regarding this policy which had been updated in October 2012.

Validated nutrition assessment tools were used to identify residents at potential risk of malnutrition or dehydration on admission and were regularly reviewed thereafter. The inspector saw that records of residents' food intake and fluid balance were accurately completed. Residents had good quality care plans for nutrition and hydration in place based on these nutritional assessments which were up to date. There was prompt access to the GP and allied health professionals for residents who were identified as being at risk of poor nutrition or hydration.

The inspector saw that several residents required a modified consistency diet. Records showed that some residents had been referred to the speech and language therapist (SALT). Specific recommendations regarding the consistency of meals and particular eating requirements were recorded in the residents' notes. Specific care plans were in place to address these needs. Staff spoken with were familiar with these recommendations and the inspector saw that they were acted upon. The inspector saw that residents who required their meals in an altered consistency had the same choice as other residents.

The inspector joined the residents at breakfast and dinner time. A menu was displayed in the dining room showing the choices available and individual preferences were readily accommodated. Most residents chose to have their breakfast in their room. Residents told the inspector they could have anything they chose for their meal. The person in charge together with the nursing staff monitored the meal times closely. Second helpings were offered.

The inspector visited the kitchen and noticed that it was well organised and had a plentiful supply of fresh and frozen food which was stored appropriately. The chef discussed with the inspector the special dietary requirements of individual residents and information on residents' dietary needs and preferences. Very detailed records were kept on residents' dietary preferences for each meal. For example, the inspector saw that one resident liked a slice of white toast with the crust removed while another preferred porridge with honey. The catering staff got this information from the nursing staff and from speaking directly with residents. The inspector noted that the chef and catering staff spoke with the residents during the meal asking if everything was satisfactory.

Weight records were examined which showed that residents' weights were checked monthly or more regularly if required. Nutrition assessment tools were used to identify residents at risk of malnutrition and were repeated on a monthly basis. The inspector reviewed residents' records and saw where residents were reassessed if they had lost weight. Three day food diaries were also maintained as required.

Records showed that some residents had been referred for dietetic review. The treatment plan for the residents was recorded in the residents' files. Medication records showed that supplements were prescribed by a doctor and administered appropriately.

The inspector saw where of sandwiches, cakes, desserts, fruits and other snacks were prepared and left ready in case residents wanted something to eat in the evening. Notices to this effect were on displayed and residents confirmed their satisfaction with the arrangements in place.

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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