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:	Sacred Heart Hospital
Centre ID:	ORG-0000654
Centre address:	Golf Link Road, Roscommon, Roscommon.
Telephone number:	090 66 26130
Email address:	julie.silke@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Catherine Cunningham
Person in charge:	Julie Silke-Daly
Lead inspector:	Geraldine Jolley
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	93
Number of vacancies on the date of inspection:	2

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 12:00	16 October 2013 18:30

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 thematic inspections providers attended an information seminar 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, visitors and staff and observed practice on inspection. Documents were also reviewed such as training records and care plans.

The staff team had completed the self-assessments and had judged that the centre was compliant in relation to both outcomes. The findings of the inspection supported this judgement. The inspector found that staff were well informed and could discuss how they ensured positive outcomes for residents that met their needs and expectations. They had a good working knowledge of up-to-date practice guidance relevant to both outcomes. Residents had been involved in focus groups formed to discuss and improve practice and continued to contribute their views in relation to both outcomes.

Residents told the inspector that staff made "great efforts" to ensure their comfort and well being including altering the dining arrangements in some units to ensure that there was adequate space for them to eat together at mealtimes. Residents confirmed they had been consulted and had participated in this change which was working well. They said that they had choices at each meal time and that catering staff provided alternatives of their choice if they did not wish to have the main dishes on offer. The inspector found that residents who had problems with eating or weight loss were supported effectively. Changes in their health status were monitored and referrals for specialist opinion were initiated and actions to support residents were included in care plans to guide the daily actions of care and nursing staff. Staff had

the skills to hold sensitive discussions with residents and relatives if appropriate to elicit their preferences and wishes for future health events and matters relating end-of-life care and their funeral arrangements. Relatives who returned questionnaires to the Authority were very positive about how care had been delivered to their loved ones and how they had been supported and involved at this time.

There was evidence of ongoing quality improvements to the services and facilities to meet the diverse nutritional needs and end of life care needs of residents including those residents with a cognitive impairment. General practitioners, nursing and care staff and allied health professionals worked in partnership with residents to identify and implement service improvements such as the meal time experience and capacity for decision making for health and end-of-life care.

There were risk management protocols and procedures in place to identify, manage and monitor risks associated with nutrition and end-of-life care. Training had been provided for staff to ensure that they provided optimal care and there was an ongoing training programme on topics related to both outcomes scheduled for staff.

There were several rooms where four residents were accommodated which complicated the delivery of end-of-life care but three single rooms had been renovated and were in use for end-of-life care. Kitchenette facilities were available for friends and family who wished to spend time with residents. There was also access to outdoor areas which had been attractively cultivated and were safe to use.

The inspector found the centre to be in compliance with the Health Act 2007(Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and National Quality Standards for Residential Care Settings for Older People in Ireland in the areas of End of Life Care and Food and Nutrition.

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 assessments, care practices and facilities were in place to support residents to receive good quality, person-centred end-of-life care and met regulatory requirements.

Care practice was based on the End of Life policy, which had been recently reviewed and was found to be comprehensive, evidence-based and contained information to guide practice effectively. The policy included guidance on the requirement to record residents' wishes in care plans, decisions and views on resuscitation, referral indicators to specialist services including the palliative care team, the use of artificial hydration and discharge arrangements where residents have expressed a wish to return home. There was a system in place to ensure that staff read and understood the policy. Other documents such as the consent policy also provided guidance for staff and contributed to how staff shared information with residents and interacted with them when discussing their end-of-life care wishes.

There had been an extensive training programme to ensure that staff had the knowledge and skills to provide end of life care effectively and staff in all roles throughout the centre had been included. Thirty six nurses, 34 care staff and 14 household staff had attended the 'Final Journeys' training provided by palliative care staff and the Hospice Foundation during 2012 and 2013. This training had covered topics such as discussing end-of-life care, assessing care needs and recognising when end-of-life care needed to be instigated, care prior to and after death and communication skills. Staff also had training on pain management and spiritual care. All staff including administrative staff are provided with a one day course on end of life care. A senior nurse manager who was undertaking a doctorate degree in palliative care provided informed guidance to staff on the implementation of policies and the complex decisions that are sometimes part of end-of-life care. Nurses told the inspector that training had extended their skills and had provided them with knowledge that helped them be proactive when addressing aspects of care such as pain relief and delivering

information on changing care status.

The centre had access to a consultant-led palliative care service which was described as readily accessible whenever advice or assessment was needed. Records showed that staff from the team had visited residents, recorded their assessments and provided guidance for staff. They also provided telephone advice when required. Nurses told the inspector that they found this expertise very valuable as it enabled them to address symptoms such as pain, discomfort and care prior to death competently.

Specialist gerontology services were provided on site by the consultant from Roscommon General Hospital. This team was actively involved in assessing changing needs and providing support and therapeutic interventions to ensure that residents had high quality care throughout their time in the centre and were referred for specialist care in a timely manner. Staff were also supported by professionals from the centre's multidisciplinary team of occupational therapists and physiotherapists and the inspector noted several examples of where good team working has resulted in positive outcomes for residents.

The inspector reviewed a range of records where decisions on end-of-life care had been recorded. Some residents told the inspector about their wishes and preferences in the event that their health deteriorated. They confirmed that staff had discussed their wishes with them. The inspector reviewed several residents' files and found that end-of-life care choices were outlined. Care plans were found to be comprehensive and there was evidence of medical input and consultation with the resident and next of kin as appropriate. Choices documented included wishes for family to be present, not to die alone, Clergy to be called, no religious input and arrangements to be made for funerals, burials and donations to medical science. Decisions agreed that involved medical interventions were clearly documented in both the medical notes and the resident's care plan. Staff confirmed that care plans were reviewed quarterly and when there was a change in the resident's condition. All the care plans viewed had been updated within the previous three months.

Residents were provided with a choice as to the place of death including an option of a single room. Family and friends were facilitated to be with the resident when they were dying. Records showed that of the 50 residents who died in the previous two years, 42 had died in the centre. There were 156 residents transferred to hospital during this period. 33% were transferred for treatment for respiratory or urinary infections and 53% were transferred for review/thrombosis/psychiatric care or blood transfusions.

There were 20 questionnaires that provided feedback on the experience of end-of-life care returned to the Authority by relatives. This represented 40% of the number circulated. Relatives were unanimous in their positive comments and described the care provided by staff in as "excellent", "exceptionally good", and one comment said that staff had provided a "home from home". There were comments on how pain had been effectively managed and how spiritual and religious needs had been addressed. Some comments highlighted how staff who had known residents' particular wishes and favourite prayers had ensured that these were said to comfort residents as required. Relatives of residents who died unexpectedly conveyed that they had been appropriately informed and supported.

There was one resident in receipt of end-of-life care at the time of this inspection. The inspector reviewed records which confirmed that the established procedures were in place and followed by staff. The resident's room was noted to be well decorated and bright with a range of assistive equipment to aid comfort.

There were religious symbols and prayers available for staff and the hospice spiral symbol was used to alert others to be respectful whenever a resident was dying. There were written procedures for staff to follow after the death of a resident in relation to the care of the deceased person's body and the notification of death. The inspector saw from records and relatives comments that family were usually present at the time of death and felt supported following the event. In situations where family could not be present staff said they remained with residents prior to and at the time of death.

Residents and staff said they were informed and supported following the death of a resident. Some confirmed that they had been able to pay their respects and participate in prayers prior to the body leaving the centre. Some staff from the centre and unit where the resident lived attend funeral services. Residents told the inspector about the remembrance service which was held annually during November. The inspector was told that invitations were circulated to families to participate in this event. There was a protocol for the return of personal possessions and staff used green bags with the hospice symbol for this purpose. The care of belongings was a high priority for staff according to one nurse and family members are included when organising /packing belongings if they wish to be involved.

Religious and cultural practices were facilitated as an integral part of life in the centre which has a Church that is in regular use. Staff recorded the ways residents wished to practice their Faith, their spiritual preferences or their wishes not to practice. Religious Priests and Ministers visited frequently and celebrated Mass and other religious services and prayers. Residents told the inspector that they were supported to continue with their religious and spiritual practices. Many residents said they looked forward to the regular Mass and prayer services.

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 found that standards in place for the provision of food and nutrition met good practice standards and regulatory requirements. Residents were provided with food and drinks at times that suited them and food available was varied and served in quantities appropriate for their needs.

Residents were unanimous in their praise for the food and the attention that catering staff, nurses and carers gave them when discussing their dietary requirements. Staff had made significant efforts to ensure that service in relation to meal times, food and nutrition was in keeping with residents' wishes and assessed needs and had formed a focus group that included all grades of staff and residents to determine what improvements could be made in this area. This had resulted in changes to the dining arrangements in some units, more consultation on daily menu choices and staff sitting with residents to have their meals to enhance the social experience. Staff said this had helped them assess what changes could be made to meal times to ensure the best outcomes for residents. They reported that they were now more conscious of noise levels, the intrusion of equipment and constant movement which they were trying to reduce to ensure a calm relaxed environment.

The inspector reviewed the menus and found that residents received a varied diet which offered choice and was nutritionally balanced. There was an emphasis on home cooking and baking with the scones provided daily a particular favourite. Catering staff interviewed could describe how residents' individual choices and preferences were accommodated. Staff on each unit spoke with residents each morning about the menu choices for the day and provide the catering staff with the individual selections. A record of specialist needs, preferences and food restrictions is kept for all residents and the chefs adhere to this when preparing the selected dishes. Changes to the menus are regularly introduced and reviewed. Recent initiatives included the addition of more fibre in smoothies which residents liked and more availability of fruit which was less popular and was a work in progress. The inspector was told that residents' views were taken seriously and underpinned changes. For example, some residents did not like mixed salads so salad vegetables were now served separately and fish was available for some residents every day to meet residents' choices.

The catering staff on duty described how residents' dietary needs are communicated among the staff team. Nurses inform them daily of changes to be made including the fortification of food which is usually the first intervention to address weight loss before supplements were considered. Catering staff are included in the focus groups and they also attend the residents' meetings to hear residents' views. One of the chefs visited units daily to talk to staff and residents. The inspector noted that food including food that was pureed was attractively presented. The instructions for foods and liquids that had to have a particular consistency to address swallowing problems were outlined in care plans and available to catering and care staff. Staff interviewed could describe the different textures and knew residents who had specific requirements.

The nutrition policy had been revised and the contents were known and observed by staff. Training was provided to ensure the procedures were appropriately implemented and to ensure that staff had appropriate skills to monitor the nutritional welfare of residents. In 2013, 40 nurses and carers had attended training on assessing swallowing

problems, food consistency and indicators for referral to specialist services. Twenty six staff had attended training on screening tools, fortification of food, supplements and recording fluid and dietary intake.

There were systems in place to intervene when a resident was at risk of malnutrition or dehydration. Residents were noted to have a nutritional assessment on admission, at three-monthly intervals and when their care needs changed. A validated screening tool was used to identify anyone who was malnourished or at risk of malnutrition. The inspector found that nutrition assessments were completed accurately and reflected residents' needs and healthcare status. Residents were routinely weighed each month and where weight fluctuations were evident there were weekly weight checks in place and additional monitoring using food and fluid intake and output charts put in place. Food and fluid records maintained were noted to be fully complete giving an accurate overview of nutrition and hydration provided.

Medical reviews and referrals for specialist advice were arranged. There is a dietician employed for the centre and she is available on request. Adequate arrangements were in place for residents to access speech and language therapy, diabetic and dental services. These services were available through referral to the Health Service Executive community services. The specialist assessments and reviews provided by allied health professionals were available in medical records and care plans. The inspector noted that nurses undertook an oral assessment on admission and that this was updated at the three month care plan review. Some residents continued to avail of dental services from their own dentist and when required staff arranged dental services.

Residents could choose to dine in the bedroom areas or to have meals in the dining rooms which were available in each unit. Dining tables were attractively laid and accommodated small groups of residents which supported social interaction. The inspector saw that there were sufficient staff including nurses available to assist at mealtimes. Residents who made varied choices about where they wished to sit were identified to ensure that staff established and facilitated their choice at each meal time. Staff sat with residents who required assistance, were respectful with their interventions and promoted independence by encouraging residents to do as much as they could for themselves. The arrangements ensured that the more frail residents received appropriate help and attention. The inspector noted in St. Catherine’s unit that mealtimes had an appropriate allocation of time and sufficient staff available to enable everyone to enjoy their meal in a leisurely way.

The inspector spoke with three residents individually and with a group of three residents and a visitor. The inspector was told that the food was very good and that there was a choice available at all meals. Residents said they that they looked forward to meals and felt the catering staff took a great interest in their likes and dislikes and ensured that the meals offered met their preferred choices.

Menus were displayed on the tables in the dining room and residents told the inspector that each morning a staff member asked them what they would like to have for lunch. There were pictorial images of dishes to aid communication and help residents identify food they liked. The inspector reviewed the four week cycle of menus and found that there were good choices provided at all meal times. At tea time on the inspection day

residents had a choice of fish cakes, fried and scrambled eggs, mashed or chipped potatoes and chopped tomatoes.

The inspector saw that residents were offered tea, coffee and snacks throughout the day. Jugs of juice and water were available in all areas where residents spent time and were replenished regularly during the day. There was a variety of food provided for the kitchens in each unit so that staff could prepare sandwiches or other snacks if needed during the night. Residents told the inspector that they could "ask for food at any time" and staff always gave them what they needed and provided a snack if they not wish to eat at main meal times.

The inspector noted that most residents used the dining rooms for the mid day meal. However, at tea times the majority had their meal by their beds which meant that an opportunity for social contact was missed. Staff were aware of this and were encouraging residents to use the dining rooms more now that these areas were attractively organised.

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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