Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Silvergrove Nursing Home Limited
Centre ID:	ORG-0000162
Centre address:	Main Street, Clonee, Meath.
Telephone number:	01 825 3115
Email address:	silvergrovenursinghome@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Silvergrove Nursing Home Limited
Provider Nominee:	Dr Mary Boyd
Person in charge:	Ann Crofts (Inglis)
Lead inspector:	Sheila McKevitt
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	31
Number of vacancies on the date of inspection:	4

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 September 2013 08:00	16 September 2013 15:30

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 the person in charge and key senior manager attended an information seminar, received evidence-based guidance and undertook a self-assessment in relation to both outcomes. The inspector reviewed policies and the provider self assessment tools relating to end-of-life care and food and nutrition submitted by the person in charge before the inspection. The person in charge had judged that the centre was compliant in relation to food and nutrition and a minor non-compliance in relation to end-of-life care.

The inspector met residents, relatives, staff and observed practice on inspection. Documents reviewed included assessments, care plans and training records. The inspectors findings reflected that of the person in charge and the centre was found to be in substantial compliance in the area of food and nutrition and some minor non-compliance in the area of end-of-life care under 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.

Food and Nutrition outcomes and practices were of a high standard. Residents and relatives spoken with confirmed this. End-of-life care practices and outcomes for residents and relatives were good. Feedback from relatives of residents who had died within the centre was extremely positive. Staff were highly praised for the kind, sensitive and friendly manner which they treated each resident.

The inspector identified some minor improvements required in the completion of resident end-of-life assessments, staff training, the provision of information to

relatives of the deceased resident, procedure for returning property of the deceased and updating the end-of-life policy to reflect said changes to practice.

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:
No actions were required from the previous inspection.

Findings:
All residents did not have a completed assessment reflecting their likes/preferences for end-of-life care. The topic had not been discussed with some residents on admission or during their three-monthly review. This was the only aspect of this Outcome reviewed on inspection.

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:
Residents received end-of-life care which met their physical, emotional, social and spiritual needs and respected their dignity and autonomy.

There was a comprehensive policy in place which reflected care provided to residents in the centre. It was developed and implemented in December 2009 and had been reviewed within the last 12 months. Staff spoken with had a good understanding of the policy and implemented care accordingly, which upheld the dignity and respected the autonomy of residents.

Relatives of residents' who had died in the previous year stated that care was provided in a kind and sensitive manner. They were facilitated to be with their loved one at the time of death and felt supported during the event and immediately afterwards. The residents' privacy and dignity was maintained and residents who shared a bedroom were offered to be transferred to a private room. The inspector was informed that when a single room was not available for a dying resident, the visitors' room was used and relatives stated they were facilitated to reside with the resident at this time. The inspector viewed the visitors' room and single bedrooms, both of which had plenty of space for a residents' bed and contained room for relatives to reside with the resident. Tea and coffee making facilities were accessible to relatives. Relatives also expressed satisfaction with the continual support and updates on the residents' condition provided to them by staff, both medical and nursing.

The person in charge stated that a remembrance mass had taken place for all the residents' who had died to date in 2013. Relatives of the deceased, staff and residents attended the service in the centre. The inspector was told it was such a lovely event that it is going to be organised annually. The person in charge also stated that she contacts relatives approximately one month post their relatives death to follow up on any support needs that might be required. However, this after care was not reflected in the end-of-life policy. The person in charge had identified this as an area for improvement in the completed self-assessment submitted to the Authority.

The end-of-life policy included a written procedure 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 and staff spoken to could articulate practice in this area. Although the person in charge said residents' belongings were returned to the relatives at a time that suited them, this was not reflected in the end-of-life policy.

The inspector was satisfied that the deceased residents' spiritual needs were met to date and relatives confirmed this in the questionnaires. There was a bedside religious locker available with all the religious relics used at the bed side of the dying resident of Roman Catholic faith. The end-of-life policy stated that the assistance in meeting residents' spiritual needs would be met and it included care of residents of the Jewish and Muslim Faith.

The centre had access to the specialist local palliative care team and community medicine liaison team both of whom attended the centre on request or when a resident was referred to their service.

Care and outcomes for residents were good. However, documentation in relation to end-of-life care required some improvements. Five residents' assessment, care plan and nursing evaluation were reviewed. One of the five residents' documents reviewed had their advanced end-of-life preferences recorded and a care plan in place. The inspector was informed that death and dying wishes were generally not discussed on admission or at the three-monthly re-assessments, but only when a residents' condition deteriorated. At this stage the resident, their next of kin and family were invited to meet with the resident's GP and the person in charge to put an end-of-life plan of care in place. The inspectors were shown documents of six residents' who had reached this stage of their life, all six had a comprehensive plan in place which included preferred place of death, choose of treatment, pain relief and nursing care agreed and signed by all parties. Two of the five residents' who spoke at length with the inspector relayed their specific end-of-life preferences. However, these were not recorded in the residents' assessment.

Staff spoken with had a good understanding of the policy on end-of-life care and related best practices. Some nursing and a small number of care staff had attended palliative care study days. However, the inspector found further education in relation to discussing death and dying with the resident was required. The person in charge acknowledged that staff required more education on how to approach this topic with a resident and had identified the need for further staff education as an area for further improvement in her self-assessment questionnaire.

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 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, when required.

The policy for nutrition was developed by the person in charge and implemented in September 2010 and had been reviewed once since this date. It was robust and provided clear guidance to staff on how to care for residents' nutritional and hydration needs. It included guidelines for care of residents with Percutaneous Endoscopic Gastrostomy (PEG). Catering and care staff had signed to say they had read the policy

and those staff spoken with had a clear understanding of its content and of their role in ensuring resident nutritional and hydration needs were met.

Residents had access to fresh drinking water and a variety of hot and cold drinks throughout the course of the day. Staff were observed offering residents a choice of hot and cold drinks with their meal and each resident was individually offered a drink between each main meal and between supper and bedtime. Residents spoken with confirmed that staff provided them with a drink if and when they requested. Relatives stated they too were always offered tea or coffee if visiting when drinks were been offered to residents' and felt this contributed to the welcome feeling in the centre. The inspector visited some residents' in their bedroom and saw they had access to a glass and a jug of drinking water which staff were observed renewing during the day. Snacks were available and served throughout the day. For example, soup was offered together with tea, coffee and biscuits at 11am. Fruit and other snacks were offered throughout the course of the day.

The inspector observed breakfast and lunch being served to the residents. Most residents were served breakfast in their bedroom and lunch in one of two dining rooms. Residents spoken with confirmed they could choose where to eat and what they wanted to eat. Breakfast trays were prepared in the kitchen at 8.15am and delivered to residents in their bedroom from a large delivery trolley. Lunch was served at 12.30pm in the upper dining room and 1pm in the lower dining room.

The choice at each mealtime was displayed on a board in each dining room in addition to the resident been asked their preferred preference prior to the meal been served. The staff member serving breakfast had a good knowledge of each residents' individual preferences, likes/dislikes, those on special diets and those who required alternation to the normal food consistency. The inspector saw the list reflecting this information was posted in the kitchen. The chef who prepared and served lunch also had an extremely good knowledge of those on special diets such as weight reducing diet, diabetic diet, high protein diet. The chef demonstrated the steps she took to ensure each resident received their required special diet and the inspector saw the food served reflected the residents' individual dietary needs.

The dining room tables were set with all required condiments, cutlery and crockery to meet the residents' individual needs. For example, butter was not available at some tables. Staff explained the rationale for this - residents seated at these tables were on weight reducing diets and therefore access to such foods was reduced by staff. The food was presented to residents in an appetising manner. Residents requiring pureed food could clearly identify what they were eating as each food group was presented separately on their plate. The quality of the food was good and the quantities reflected the residents' individual dietary requirements, which were also reflected in their care plan.

Residents spoke highly of the quality of the food and the manner in which it was cooked and served. Plenty of care staff were available to assist residents during both meal times. They had a good knowledge of each residents individual capabilities and were observed encouraging and promoting residents to be independent in a sensitive manner. Breakfast was a relaxed affair some residents were served sitting up in bed, others

sitting out in a chair. Lunchtime service in both dining rooms was also relaxed, residents sat two or four per table in the upper dining room and all residents sat at one large table in the lower dining room. The environment was home like, residents' chatted amongst themselves and to staff.

Clinical documentation was of a high standard. Five assessments, care plans and nursing evaluation notes were reviewed. Residents were assessed on admission and reviewed three monthly with a validated assessment tool for food and nutrition, skin integrity and oral hygiene. A baseline weight and height was recorded on admission and monthly thereafter or more frequently if a resident was identified as being at risk.

Assessments were detailed and reflected the residents' individual needs. Each need had a corresponding care plan, which detailed the nursing care, medications/food supplements prescribed, specific care recommendations from visiting inter disciplinary team members and the GPs instructions. Assessments and care plans were reviewed by staff nurses every three months and amendments made intermittently as the residents needs changed. There was no resident on food or fluid record charts or identified as having weight loss at the time of inspection.

The provider's self-assessment indicated that access to medical and peripatetic services was good and the inspector found there was no delay in any resident been referred or reviewed as required. Residents and their relatives confirmed this to the inspector with one relative praising the prompt care provided when their loved one resident was not tolerating a PEG feed prescribed and the measures taken to address the issue by all inter disciplinary team members involved.

Staff had received comprehensive training received by staff in relation to food and nutrition and demonstrated and articulated good knowledge of how to provide optimal care for residents.

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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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:	Silvergrove Nursing Home Limited
Centre ID:	ORG-0000162
Date of inspection:	16/09/2013
Date of response:	23/10/2013

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:
Residents end-of-life care preferences/wishes were not assessed or recorded.

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:
We have developed a detailed questionnaire to reflect individual resident's wishes in their End of Life Care Plan. Initial assessment will be carried out on admission and reviewed 3-monthly thereafter.

Proposed Timescale: 23/10/2013

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

Outcome 14: End of Life Care
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 policy did not reflect the support provided to relatives post the death of a resident or the procedure for returning belongings to relatives of the deceased. **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:** Silvergrove Nursing Home's policy on resident's personal property and possessions has been updated to include the effective return of residents' belongings to relatives/next of kin. Silvergrove Nursing Home's policy of End of Life Care has been updated to include the support which is given to family / next of kin following the death of their relatives.
Proposed Timescale: 23/10/2013