

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Teach Altra Nursing Home
Centre ID:	ORG-0000297
Centre address:	Scarteen, Newmarket, Cork.
Telephone number:	029 61 166
Email address:	teachaltra@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Newmarket Nursing Home Limited
Provider Nominee:	Bartholomew Daly
Person in charge:	Nuala Boyd
Lead inspector:	Mary O'Mahony
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	43

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: 03 April 2014 11:30 To: 03 April 2014 20:00

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 in Teach Altra Nursing Home which focused on two specific outcomes, End of Life Care, and Food and Nutrition. In preparation for this thematic inspection providers and persons in charge attended an information seminar, received evidence-based guidance and undertook a self-assessment in relation to both outcomes. The inspector reviewed policies and relevant documentation prior to the inspection. The inspector met residents, relatives and staff, and observed practice on inspection. Documents in the centre were also reviewed such as, training records, residents' care plans, medication management charts, menus and records pertaining to deceased residents.

The person in charge who completed the self-assessment questionnaires, came to the conclusion that the centre had a minor non-compliance with regard to end-of-life care and a minor non compliance with regard to food and nutrition. Overall, the inspector's findings correlated with the self-assessment questionnaire results submitted by the provider. The inspector found minor non-compliance in the area of food and nutrition and 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 National Quality Standards for Residential Care Settings for Older People in Ireland.

Of the ten next of kin questionnaires sent out by the person in charge on behalf of the Authority, one had been returned prior to 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:

Non Compliant - Minor

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

There were written operational policies and protocols in place for end-of-life care in the centre. Staff to whom the inspector spoke were familiar with these policies and were aware of how to support residents and families at the end-of-life stage. The inspector spoke with the senior nurse, care staff, cleaning staff, administration staff, laundry and kitchen staff. They told the inspector how they would support the residents and relatives and said that training was available to them in all aspects of end-of-life care.

The inspector viewed training records which supported what the staff had said and these indicated that palliative care issues including spiritual care, psychological care, pain control and communication issues had been addressed in this training. Training was availed of both in the centre and externally.

Religious and cultural practices were facilitated. On the morning of inspection the residents were attending a religious service. The inspector spoke with the visiting local priest who told the inspector that he visited the centre weekly and was available for spiritual and end-of-life care at all times. The centre's policy included guidance in facilitating and engaging in different cultural practices at end-of-life, where required.

A comfortable library room was available for family and friends to use as an overnight facility and the person in charge (PIC) explained how she converted it into a bedroom, if a visitor wanted to stay overnight. Facilities were provided for relatives to have refreshments and snacks at the coffee bar as well as from the kitchen staff in the centre. Open visiting was facilitated at the end-of-life stage.

The inspector reviewed a sample of care plans of deceased residents and noted that the residents were regularly reviewed by the general practitioner (GP) and that appropriate attention and care was given. The inspector saw evidence that the nursing and care staff had attending to the holistic needs of the residents. There was evidence that

medication management was regularly reviewed and closely monitored by the GP. There were also indications that the relatives were present with the resident.

The inspector also viewed the care plans and spoke to family members of residents who were receiving palliative care on the day of inspection. These relatives were able to confirm to the inspector that the GP and the person in charge had discussed end of life wishes with them, as advocates, for their relatives. A friend of a resident spoke with the inspector and described how she observed night staff providing respectful and dignified care when a resident was dying. The care plans revealed that assessments were in place to ensure good oral care, skin assessments and pain control as well as fluid and nutritional intake where appropriate.

The GP spoke with the inspector and explained how he liaises with the geriatrician in the local hospital, as well as the geriatrician in Cork, to ensure that best practice initiatives were implemented. He explained how the centre was well supported by the specialist team from the hospice. The GP had his own syringe driver which facilitated speedy access to symptom control when required. Records in the centre supported this and the inspector saw that over 90% of residents, who died in the previous two years, were facilitated to die in the centre. There were processes in place to ensure involvement of staff and families in end-of-life decision making, when this was required.

The GP and the person in charge described to the inspector how they ascertain the residents' wishes for their future care and explained how the families are consulted in the process, if the resident consents to this. However, the inspector noted that on most occasions these wishes were not recorded in a formal way in the resident's care plan. This had been identified by the person in charge in the self assessment questionnaire. She told the inspector that this was under discussion at the moment and there were plans to begin these care plans when staff had the appropriate training.

The centre use the Hospice Friendly Hospitals end-of-life symbol when a resident was approaching the end-of-life stage. The person in charge informed the inspector that she had ordered other items, which she had heard discussed at a recent training session, in preparation for this inspection. A remembrance service was held yearly in the oratory and staff, residents and families attended this.

The person in charge stated that when a resident died in the centre the family or representatives were given advice on what to do following the death. Information leaflets on how to access bereavement and counselling services were not yet available but these were among the items which the person in charge stated she had planned to order. Staff spoke to the inspector about a recent death and how the family had requested a specific song for staff to sing as the resident's body was removed from the centre. The staff had gathered to fulfil this wish and the family were very grateful. Staff and residents were supported following the death of a resident.

There was a protocol for the return of personal possessions. Samples of inventories of residents' personal property were reviewed. These were signed and updated regularly. The centre had a specific bag, with the logo of Teach Altra displayed on it, for the return of residents' clothing to the family. The inspector spoke to the laundry staff member who explained how the resident's clothes are laundered and packed following death.

She indicated that she had received training in end-of-life care and how she would ensure that fresh sheets were available daily for a person approaching the end of their life.

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:

Non Compliant - Minor

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The inspector reviewed the self-assessment questionnaire for the centre and the policies on nutrition, mealtimes and hydration. These were found to be relevant and comprehensive and were seen to be implemented in the centre.

The inspector viewed training records which indicated that staff had attended a broad range of training. These education sessions were ongoing with an external provider, the dietician and a speech and language therapist (SALT).

The inspector observed mealtimes including dinner, afternoon tea and the evening meal. The inspector sat at the dining table at the invitation of a group of residents. The told the inspector that they were very happy with the choice of meals on offer. The residents spoke to the inspector about the time at which meals are served as well as the fact that their choice of dining venue was respected. On the day of inspection the inspector noticed that there were three choices on the menu and the inspector sampled the food on offer. It was served hot and was very well presented. The inspector noted that staffing levels were adequate to meet the needs of the residents during mealtimes. Residents having their meals were appropriately assisted and received their meal in a timely manner. A staff member was assigned to sit at each dining table to observe and support any resident requiring assistance. Some residents were receiving assistance on an individual basis and the inspector observed that the staff members were assisting the residents carefully and in a respectful manner.

The dining room was bright and spacious. The residents were able to dine with dignity and there was a large conservatory attached to the dining room which afforded scenic views of the surrounding countryside. The tables were nicely decorated and the crockery and cutlery were of good quality.

Snacks and hot/cold drinks including juices and fresh drinking water were readily

available throughout the day. The inspector reviewed records of resident meetings chaired by the centre's advocate. It was evident that issues raised by residents, as regards to food, were addressed. The complaints log was also reviewed and there was no evidence of complaints concerning food.

The inspector spoke with the chef who said that she regularly met with the person in charge and the senior nurse to discuss the residents' dietary needs. The chef showed the inspector her files, which contained relevant information, including a copy of the most recent assessments carried out by the speech and language therapist, the dietician and a record of residents' food preferences. The chef and the kitchen staff indicated that they received training in food safety, food hygiene and menu design.

There was a four weekly menu rotation in place and the chef stated that if a resident did not like what was on the menu, an alternative was available. Residents stated that they could have anything they wanted to eat. There was evidence that ample choice was available for lunch, and the inspector heard residents indicate their individual choices to the staff. Staff were seen to be attentive and knowledgeable about the residents and were able to tell the inspector how they would cope with a resident who had swallowing difficulties or a resident who appear to be choking.

Documentation submitted to the Authority indicated that:
26 residents (55%) were on a puréed/mashed diet
1 residents (0.5%) were on nutritional supplements
8 residents (25%) were on a diabetic diet
0 resident (0%) was on fortified diet.

This was confirmed by the person in charge on the day of inspection.

A sample of medication administration charts reviewed by the inspector indicated that nutritional supplements were rarely prescribed by the GP. He told the inspector that he relied on the fact that there was a varied and nutritious diet available to meet most residents' needs and the diet was modified and fortified when indicated. If a resident was not able to eat the food on offer a supplement was prescribed. The inspector noticed that one resident had this prescribed, following assessment of medical status.

Subcutaneous fluids were also available for residents who were not able to partake of oral fluids. Fluid and food records were maintained for residents assessed as 'at risk'. However, the inspector noted that these were not always accurately completed.

The inspector also joined the residents for tea and observed that mealtimes were seen by the residents as social occasions. Residents were seen to engage in conversation and one resident entertained the others by singing at the end of the meal.

The evening meal was served from 16:30 onwards and the inspector observed that there was a choice of menu on offer as well as a selection of home baking.

All residents had access to dietary, dental, as well as speech and language services and there was evidence of this in the sample of care plans reviewed. The inspector noted that all residents had a malnutrition universal screening tool (MUST) assessment and

that this was repeated three-monthly or when required. A food chart was also completed for new admissions. If a dietary need or weight loss was identified the GP was informed and the appropriate service contacted to review the resident.

Residents with diabetes were provided with the appropriate diet and had a comprehensive care plan in place to support their care.

Training for staff in dysphagia (difficulty in swallowing) was carried out and oral care assessments had been performed on some residents. Care plans were in place to provide guidance on oral care. Staff spoken with by the inspector were knowledgeable on this subject.

The inspector spoke to one resident who was served his meals in his bedroom and he told the inspector that he was given his choice from the menu at each meal. The inspector noted that the meal appeared appetising and was served hot.

While residents were not in a position to prepare their own food there was a coffee dock in the centre where any resident, who was able to do so, could make coffee and meet with visitors.

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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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Teach Altra Nursing Home
Centre ID:	ORG-0000297
Date of inspection:	03/04/2014
Date of response:	15/04/2014

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 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:

The end-of-life wishes of residents were not recorded in the resident's care plans.

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:

The "Resident Comprehensive Assessment Form" which is filled up for each resident on admission to Teach Altra is being updated to contain a more comprehensive Part 12 Spirituality and Dying. This will include a section for recording "Patient wishes regarding death/dying/resuscitation/advanced directives." Also a specific "End of life

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

Care Plan" will be set up for the resident, if and when the need arises, taking the resident's recorded wishes into consideration.

Proposed Timescale: 30/04/2014

Outcome 15: Food and Nutrition

Theme: Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some residents who were assessed as 'at risk' did not have a complete and accurate record of their food and fluid intake maintained.

Action Required:

Under Regulation 20 (7) you are required to: Implement a comprehensive policy and guidelines for the monitoring and documentation of residents nutritional intake.

Please state the actions you have taken or are planning to take:

Action has been taken to ensure that staff always document and sign 'at risk' resident's nutritional intake.

Proposed Timescale: 15/04/2014