

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Clarehaven Home
Centre ID:	ORG-0000511
Centre address:	St. Canice's Road, Glasnevin, Dublin 11.
Telephone number:	01 704 4430
Email address:	gmdnc@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Michelle Forde
Person in charge:	Mary Flanagan
Lead inspector:	Leone Ewings
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	25
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:

03 April 2014 11:00

03 April 2014 18:00

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 which focused on two specific outcomes, End of Life Care and Food and Nutrition. In preparation for this thematic inspection providers were invited to attend an information seminar, received evidence-based guidance and undertook a self-assessment in relation to both outcomes. The inspector reviewed policies and analysed surveys relatives submitted to the Health Information and Quality Authority (the Authority) prior to the inspection. The inspector met residents, relatives, staff and observed practice during the inspection. Documents were also reviewed such as training records and care plans.

The person in charge who completed the provider self-assessment tools had judged the centre to be in substantial compliance under both outcomes. The provider had identified actions within the self-assessment documents which prompted some improvements under end of life care, and supports put in place for relatives to stay on site more comfortably if required.

The inspector found that residents' end-of-life needs were well managed with good access to medical and specialist palliative care and residents wishes to be cared for in their final days within the centre had been supported and encouraged. All care plans in place provided a comprehensive detail and strong evidence of family meetings and review, the inspector found that residents' end-of-life needs were well managed with good access to medical and specialist palliative care. All care plans reviewed provided a comprehensive assessment of needs and ensured that residents had been consulted in relation to their individual wishes. The feedback from the six returned questionnaires was mainly positive about the individual experience of relatives and significant others. Four questionnaires received prior to inspection and

two received following the inspection were reviewed and rated the quality of care and communication at a high standard.

The food and nutritional needs of residents were also met to a high standard. There was adequate access to allied health professionals for residents such as medical, occupational therapy, dental and speech and language therapy. The food provided to residents was appetising and nourishing. Residents were facilitated to maintain their independence and adequate and discreet supports were provided by staff as required. Residents and relatives reported high levels of satisfaction with the service provided. The dining experience was a positive, social experience for all residents.

On the day of inspection the inspector found the centre to be in full 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.

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

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The end-of-life care provided to residents was to a very good standard. The inspector saw that residents received end-of-life care which met their physical, emotional, social and spiritual needs and respected their dignity and autonomy. Records such as assessments, care plans, end of life discussions and transfer details of the deceased remains were completed with individual guidance. Written information on services and supports available to relatives was also well communicated and given at appropriate times.

There was a comprehensive end-of-life policy in place which reflected the care relatives said was provided to their dying relative in the centre. It was reviewed last in February 2014. Staff spoken with had an understanding of the policy and implemented care accordingly which upheld the dignity and respected the autonomy of residents at the centre.

No resident was receiving end-of-life care at the time of inspection. Staff said residents were given the choice of where they would like to die. One of the resident spoken with said they wanted to stay at the centre for the rest of their lives if possible. Residents confirmed they were asked about their preferences regarding end of life care and options available to them. The end of life self assessment document stated that return home was not an option. However, on further evaluation and discussion with resident and review of relatives' questionnaires there was evidence that returning home was not considered in depth. Transfer to hospital was spoken about and many residents had expressed that they did not wish to be transferred to an acute hospital if at all possible. However, further to discussion with staff with regard to individualised needs of each resident no resident had requested a return to their original home over the last two years. The inspector confirmed with residents that they wished to stay at the centre and considered the centre their home. The inspector noted that 9 out of the 10 residents who had died in the past two years had died in the centre. A number of residents occupied shared bedrooms and improvements had taken place to provide access to a single room (if available) for end of life care. Arrangements were in place to facilitate couples at the centre to live together also. Relatives confirmed that a single room had

been made available when required.

There was a small visitor's room which contained two large comfortable reclining chairs for relatives to rest. This had recently been put in place. Relatives who completed questionnaires confirmed they were facilitated to stay with their loved one when they were dying. Tea and coffee making facilities were also available, and access to outdoor space and seating on the premises. Feedback received from relatives stated that the end-of-life care provided was good and ensured the resident was comfortable and pain free and they were very satisfied with the medical care provided by the general practitioners (GP) visiting the centre.

The centre had access to the community based palliative care team. The inspector was informed that prompt referral and review from the team was provided whenever necessary. In house expertise was available and a clinical nurse manager had completed post graduate qualifications in palliative care and had an overall responsibility for co-ordinating on the Claremont campus. Meetings took place every 6-8 weeks and there was a link nurse is on each of three units on the campus. Training has taken place with regard to individualised end of life care and 75% of staff had already attended. Detailed death review meetings now took place as a result of a quality improvements initiative from the palliative care services which started in 2011 to support staff involved with end of life care. The audit tool reviewed care planning, family meetings and documented wishes of the resident and if spiritual and medical needs of residents were met as a result of care offered by the service.

Nursing documentation was reviewed by the inspector and confirmed that nurses recorded residents' death and dying wishes/ preferences at the time of their initial assessment or during their three monthly assessment review. A six monthly family meeting also took place and this also prompted changes in the end of life care plans in place. The inspector was informed that some residents, their families together with the GP had decided that the resident was not for cardio pulmonary resuscitation (CPR) or active measures, but for all 'comfort' measures. However, in practice should a transfer to hospital be medically necessary that the transfer to hospital was ticked on all records reviewed. In practice a review of residents transferred to hospital by the provider indicated that 11 residents on 20 occasions had been transferred and none were for end of life care. The main reasons for transfer were acute and related to treatments required for infections, post-fall, and other medical interventions required of an immediate medical nature. The scope of practice of many nursing staff working at the centre included training completed on administration of subcutaneous fluids, and syringe driver for the delivery of subcutaneous medication. Pharmacy arrangements were in place to access out of hours if necessary.

Residents' religious needs were facilitated by the local priest. The Sacrament of the sick was also provided and the priest sought at the residents' request. The centre is located proximal to the local church facilities in the community and residents spoke of visiting from time to time and enjoyed the mass which was held in the day room of the centre on a weekly basis.

Relatives stated that there were sufficient staff on duty at the time of their relatives death. One relative appreciated being notified in a timely way that she needed to be

present as her relatives condition was deteriorating. However, the ongoing communication and worry about leaving and not being present was a difficulty, and she indicated that further communication and being able to return home for a shower/rest would have made it easier for them at this stressful time. The end of life policy included details about caring for the remains of a deceased resident and the return of personal possessions to loved ones. The Irish Hospice Foundation equipment and symbols were available for use in the centre. The inspector was informed that following the death of a resident staff used an Irish Hospice canvas bag to return personal possessions.

Information was available to relatives on the death of a loved one. The inspector noted that the information available was centre specific and there was written information given further to family meetings. For example, the inspector reviewed a file which confirmed a leaflet 'Understanding the changes which occur before death' to a family as a support to read following the meeting. Staff informed residents' about the funeral arrangements and those who wished to attend the funeral were facilitated. The policy confirmed a sympathy card was sent to relatives when a resident died and an annual memorial service was held in November each year to remember all residents who had died in the past year.

Education records showed staff had received training in relation to the provision of end of life care, and clinical training on symptom management and the use of the syringe driver when required. The documentation reflected a commitment to providing individualised end of life wishes for each resident. Staff interviewed gave an example of resident who had passed away and the relatives were arranging the funeral, and his wishes had been communicated and documented in detail, and this could be clearly communicated to the relatives with regard to specific arrangements for his remains.

Judgement:

Compliant

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

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, served and was wholesome and nutritious. Assistance was offered to residents in a discreet and sensitive manner, when required. Residents had a choice of meals at lunch and tea time. The small size of Clarehaven and the layout of the day dining area facilitated a

comfortable dining experience. The inspector reviewed lunch and tea time meals with the residents on the day of the inspection.

The policy on food and nutrition had been reviewed on several occasions, most recently in May 2012; it was due for further review in May 2014. It was robust and provided clear guidance to staff on how to care for residents' nutritional and hydration needs. The inspector saw that most staff had signed to say they had read and understood the updated policy and others were in the process of reading it. Catering and care staff had demonstrated a clear understanding of its content and of their role in ensuring residents' nutritional and hydration needs were met.

There was also a policy on guidelines for care of residents with Percutaneous Endoscopic Gastrostomy (PEG). There were no residents receiving any nutrition via a PEG feed on this inspection.

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 stated they were 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. Residents told the inspector they had a glass and a jug of drinking water by their bed which staff renewed daily. Snacks were available and served throughout the day. For example, soup was offered together with tea, coffee and biscuits mid-morning. The appropriate equipment to meet the resident's needs such as beakers with lids/non slip mats and plate guards were found to be available for use.

The inspector observed lunch at 12.30hrs and tea at 16.45hrs being served to the residents. Residents confirmed they could choose where they wanted to eat. Residents had access to a communal day/dining room, which had a separate dining section linked to the kitchen. Catering staff, prepared meals from the winter menu and the chef served up to each resident present in the dining room, and smaller numbers eating in their rooms. There was a choice of a choice of main course and dessert available. Soup course was available earlier midmorning and could also be taken with meals. Catering staff knew the residents likes/dislikes and needs. For example, some residents needed gentle verbal reminders to try their meals and re-direction. Residents spoken with told the inspector that they enjoyed the food service. The food service was visible to residents and the aroma of the foods added the lunch time food service. Residents could view the food prior to making a choice. The lunch was prepared and cooked in the main kitchen in Seanchara and was transported in a bainmarie prior to each mealtime. The choices available to residents were displayed on a chalk board in the dining area. Tables were attractively set and condiments and cutlery available for each resident. Residents completed a meal choice form the day previous and the resident was asked their preferred choice again prior to the meal been served. Residents who required a minced or smooth pureed diet got a choice of meals, the menu which was the week 1 winter menu was delivered and was consistent with the published menu given to the inspector.

The catering staff had a good knowledge of those on special diets such as weight reducing, coeliac, diabetic, healthy heart, high protein and high calorie diets. They described the steps taken to ensure each resident received their required special diet

and the inspector saw the food served reflected the resident's individual dietary needs. Catering and care staff spoken with had a good knowledge of each resident's individual preferences, likes/dislikes, those on special diets and those who required alternation to the normal food consistency. Details of fortification of foods with milk and individual requests for likes and dislikes were also noted. The inspector saw that catering staff had all of this information available to them on a dining list in each unit kitchen, including short term residents on respite stays.

The dining room tables were set in an attractive manner with all required condiments and cutlery to meet the residents' individual needs. The food was presented to residents in an appetising manner. Residents requiring smooth pureed or minced moist 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 each resident's individual dietary requirements, which were also reflected in their care plan. Staff were available to assist residents at mealtimes in both units. They were observed encouraging and promoting residents to be independent in a sensitive manner.

Residents' chatted amongst themselves and to staff while enjoying their lunch. Residents spoke highly of the quality of the food and the manner in which it was cooked and served and confirmed that feedback was sought from them at their residents' meeting. A number of examples of resident feedback were given to the inspector. For example, a recipe for a residents stew was on the menu. The inspector was told that any food waste was reviewed on an ongoing basis to ascertain popularity of certain dishes among residents, and aid menu planning.

The tea time service was of a similar service provision to the lunch time. Choices included coddle or fish cakes and side salad. In addition some residents were seen enjoying their own choice of meals including bacon rasher and sausage at this time which was a la carte. Further to a review of the two week menu the inspector found that a hot food choice was always available to residents at tea time, with a further supper choice of sandwiches or wraps, cake and a hot drink at 20.30hrs.

Clinical documentation was of a very good standard. 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 resident's 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 GP instructions.

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 being referred or reviewed as required. There was an in house speech and language therapist available to assess residents. Access to speech and language dietetics and dental assessments was good, with clear documentation of assessment and regular reviews. The catering manager confirmed that updates on residents' assessments and review were available on a shared drive and updated weekly. Peripatetic staff were also involved with

providing education and support to both care and catering staff. Education records showed staff had received training in several areas in relation to food and nutrition including dysphagia, modified texture diets, malnutrition screening and referral criteria.

Nursing and care staff demonstrated a good knowledge of each residents nutritional requirements and meals were a social and relaxed occasion. Mealtimes were well supervised and protected from any form of medication administration on the day of the inspection. Small fridges contained cold drinks and snacks which were available at all times to residents. Residents confirmed to the inspector that family occasions, birthdays etc were celebrated at the centre with provision of cake and high tea, and resident could invite guests if desired. Pictorial menus were not evident at the time of this inspection, but staff commented that this is something which had been in place in the past. However, staff were clearly seen offering visually both options for each course to residents with cognition difficulties which aided choice for the individual resident.

Judgement:

Compliant

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 all the people who participated in the inspection.

Report Compiled by:

Leone Ewings
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority