**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

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| **Centre name:** | Aras Mhic Dara |
| **Centre ID:** | ORG-0000626 |
| **Centre address:** | An Cheathrú Rua,<br>Co na Gaillimhe,<br>Galway. |
| **Telephone number:** | 091 869 010 |
| **Email address:** | mary.curran2@hse.ie |
| **Type of centre:** | The Health Service Executive |
| **Registered provider:** | Health Service Executive |
| **Provider Nominee:** | Catherine Cunningham |
| **Person in charge:** | Mary Curran |
| **Lead inspector:** | Jackie Warren |
| **Support inspector(s):** | None |
| **Type of inspection** | Unannounced |
| **Number of residents on the date of inspection:** | 40 |
| **Number of vacancies on the date of inspection:** | 15 |

## 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: |
|---|---|
| 18 June 2014 13:00 | 18 June 2014 18:30 |

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

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| 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 and reference is also made to one aspect of Outcome 11.

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 met residents and staff, observed practice in the centre and reviewed documents such as menus, care plans and medical records. The inspector also read survey questionnaires completed by relatives and received by the Authority following the inspection.

The person in charge, who completed the provider self-assessment tools, had judged the centre to be in minor non-compliance under both outcomes.

The inspector found that residents' end-of-life care was well managed and there was good access to medical and specialist palliative care. Records indicated that residents received a good standard of care in their final days and relatives indicated in feedback questionnaires that they were very satisfied with the end of life care that their loved ones had received.

Residents' nutritional needs were well met. Residents were complimentary of the food provided. The menu was varied and suited to residents' specific needs. Food appeared wholesome and nutritious and residents requiring assistance were supported in a respectful and appropriate manner. Residents had regular nutritional assessment and monitoring and were reviewed by dieticians, speech and language therapists and dentists as required.

Improvements, however, were required in care planning for nutritional care and assessment of end of life wishes and these requirements are discussed in Outcome 11 of this report.

**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

**Findings:**
During this inspection, the inspector viewed the processes in place for the assessment and management of nutritional care. Other aspects of health care were not reviewed at this inspection.

Although there was a good standard of nutritional assessment and review noted which is discussed in outcome 15 of this report, the inspector found that some of the nutritional care plans viewed had not been suitably updated to provide guidance to staff. For example, while recommendations of the dietician and speech and language therapist were clearly recorded on files and were known to staff who spoke with the inspector, some care plans had not been updated to reflect this information. In addition, the recording of food intake charts which had been developed for some residents, was inconsistent and not sufficiently detailed. Although the types of food and beverage throughout the day were recorded, the quantities were not clearly specified.

**Judgement:**
Non Compliant - Moderate

***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

**Findings:**
The inspector was satisfied that caring for a resident at end-of-life was regarded as an important part of the care service provided. Based on records reviewed, care provided to residents approaching in of life was to a good standard, however, improvement was required in assessment and recording of end of life wishes.

There were no questionnaires from relatives available at the time of inspection, but following the inspection the inspector reviewed questionnaires returned by the relatives of some former residents. Relatives stated that they were very satisfied with the care which had been provided before, during and after the death of their loved ones. They stated they were made feel welcome and were facilitated to stay overnight and be with the resident during his/her last days. Relatives reported that residents' wishes, with regard to their place of death were respected. The person in charge had stated during the inspection and in the pre-inspection self-assessment questionnaire that residents in shared rooms nearing end of life would be transferred to single rooms and that there was also a palliative care room available. However, some relatives commented that their relatives had not been accommodated in single rooms at end of life and they did not know the reason for this. Following the inspection the person in charge confirmed that from the start of 2011 onwards that no residents had received end of life care while sharing with another person, although some residents were nursed as sole occupants of twin or multi-occupancy rooms.

There was an open visiting policy and family and friends were facilitated to be with the resident approaching end of life. There was ample communal and private areas and a portable bed was available to facilitate families remain overnight. Refreshments were available for relatives.

The person in charge stated that the centre maintained strong links with the local palliative care team, which provided support to families and guidance to staff. The inspector saw that there was good access to this service when required and that recommendations from the palliative team had been recorded in detail in residents' files and had been implemented by the staff. The palliative care team had recently provided training to staff in areas including care of pressure areas, use of morphine pumps and mouth care.

Residents' spiritual needs were well met at all times, including at end of life. Mass was celebrated in the centre each week and the sacrament of the sick was administered as required. In addition, residents could join in daily Mass and other religious celebrations from the local church by video-link and could view these events on the televisions in their bedrooms. A priest visited the centre at least once a week and was available more frequently to support residents at end of life and their families. Arrangements could be made for residents to repose in the centre, where residents and members of the local community could come to pay their respects.

In 2013 the person in charge introduced an event to commemorate deceased residents of the centre. She organised a commemorative Mass in November, when the residents who had died within the previous year were named and a candle was lit in each person's memory. Current residents and relatives and friends of deceased residents were invited to attend the Mass. A decorated memorial tree, on which each deceased resident was

identified, was displayed in the day room for the Month of November. The person in charge intended for this to be an annual event.

The inspector viewed a sample of records, including one for a deceased resident. Records indicated that residents were comprehensively assessed on admission and at regular intervals thereafter. There was evidence that residents were regularly reviewed by their GP and with increased frequency as they approached end of life. Care plans were developed to guide staff in end of life health care issues such as managing pain, peg feeding and catheter care. However, inspector found that suitable assessment of residents' end of life wishes had not been undertaken. In the sample of files viewed the end of life and palliative care sections had not been completed and there was no record that staff had discussed this topic with residents. While it was not documented in care plans, the person in charge knew the residents and their wishes well and confirmed that she had discussions around end of life preferences with some next of kin.

No deficits were identified in relation to the numbers and skill mix of staff and their ability to meet the needs of residents at end of life.

**Judgement:**
Non Compliant - Moderate

***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 was satisfied that residents were provided with food and drinks adequate for their needs, although some improvement to the documentation of nutritional records was required and this is discussed in outcome 11 of this report. Food was suitably prepared, cooked and served. Residents were offered a varied diet that included choice at mealtimes and in a way that met their needs. The inspector noted that staff provided assistance to residents in an appropriate and discreet manner. Residents who spoke with the inspector were very satisfied with the standard of catering and confirmed that they were offered choices at mealtimes.

The inspector spoke with the chef who devised a four-weekly menu that was interesting and varied based on residents' preferences and requests and in consultation with a dietician. There were two meal choices each day, although alternatives would be arranged for residents who wanted something else to eat. The meal choices were displayed on a blackboard in the dining room each day.

The chef told the inspector of residents' likes, dislikes and dietary needs and up-to-date dietary information was also documented in the kitchen. Some residents required special diets or a modified consistency diet and this was provided for them. The chef adjusted meals with regard to health issues such as diabetes, high cholesterol and weight control. Staff were aware of residents' special dietary requirements and were knowledgeable of how these meals would be served to residents. The inspector noted that they had the same choices as other residents and the food was suitably presented. For example, the chef made confectionery and desserts with sugar substitutes for residents on diabetic or low calorie diets.

The inspector noted that residents were offered a variety of snacks throughout the day, including drinks, soup, fruit and baked products. In addition, snacks were available to residents if they wanted something to eat in the evenings or during the night. Residents confirmed that food, drinks and snacks were available to them at all times, including night time if they were required.

The majority of residents ate in either of two dining rooms, although some residents preferred to have their meals in their bedrooms. The atmosphere during the mealtimes was relaxed and unhurried. Staff sat beside residents who required assistance with eating while encouraging other residents to eat independently.

The inspector reviewed a sample of records and found that each resident had nutritional assessment, using a recognised assessment tool, carried out on admission and at three-monthly intervals thereafter or more frequently if required. Residents' weights were routinely monitored and recorded monthly. Where specific nutritional needs or assessed risks had been identified measures had been implemented to address these risks. The inspector saw that referrals had been made to dieticians, dentists and speech and language therapists whose reports and recommendations were recorded in residents' files. In addition to weight related concerns, care plans for other aspects of health and wellbeing were linked to nutritional care plans. For example, nutritional needs for the prevention of pressure ulcers were reflected in nutritional care plans and care plans for constipation recommended dietary interventions such as specified daily fluid intake, prune juice and addition of bran and linseeds.

**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:*

Jackie Warren
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

**Health Information and Quality Authority**
**Regulation Directorate**

**Action Plan**

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

**Provider's response to inspection report**[1]

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|---|---|
| **Centre name:** | Aras Mhic Dara |
| **Centre ID:** | ORG-0000626 |
| **Date of inspection:** | 18/06/2014 |
| **Date of response:** | 12/08/2014 |

## 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 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:**
Some nutritional care plans had not been suitably updated to provide guidance to staff.

The recording of some food intake charts was inconsistent and not sufficiently detailed. Although the types of food and beverage throughout the day were recorded, the quantities were not clearly specified.

**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.

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

**Please state the actions you have taken or are planning to take:**
The comments of the inspector have been taken on board by Catering team and all staff. Staff members have attended a nutrition course facilitated by the INMO/ NMPDU. The care plans are amended following consultation with residents and updated to provide guidance to staff. Complete and ongoing

The Dietician will organise a training session on completing food record charts for all staff. 30.11.2014

**Proposed Timescale:** 30/11/2014

**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:**
Suitable assessment and documenting of residents' end of life wishes had not been undertaken.

**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 inspector's comments are noted.

Nursing staff are in the process of discussing how best to approach end of life discussions with the residents. All staff will avail of end of life care training provided by INMO/NMPDU. 31.12. 14.

All care plans will be reviewed and developed with the resident / representative to include documented assessment of resident's end of life and palliative care wishes including choice as to the place of death, the option of a single room or returning home. 30.01.15

**Proposed Timescale:** 30/01/2015