

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Glebe House Nursing Home
Centre ID:	ORG-0000039
Centre address:	Kiltarnan Care Centre, Glebe Road, Kiltarnan, Dublin 18.
Telephone number:	01 4824001
Email address:	glebehouse@cowpercare.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Cowper Care Centre Limited
Provider Nominee:	Seamus Shields
Person in charge:	June Margaret Annesley
Lead inspector:	Helen Lindsey
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	47
Number of vacancies on the date of inspection:	0

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: 24 June 2014 07:45 To: 24 June 2014 16:00

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 one day thematic inspection which focused on two specific outcomes, end-of-life care and food and nutrition. In preparation for this thematic inspection providers attended an information seminar, received evidence-based guidance and undertook a self-assessment in relation to both outcomes. The inspector reviewed policies, the self assessment completed by the person in charge, and questionnaires which relatives submitted to the Authority prior to the inspection. 10 had been sent out by the provider and 2 were returned. The inspector met residents, relatives, staff and observed practice on inspection. Documents were also reviewed such as training records and care plans. The person in charge who completed the provider self-assessment tool had judged that the centre was compliant in relation to both outcomes.

While areas of non compliance were identified under the end-of-life care, nutrition and hydration, and health and social care needs outcomes, overall the inspector found a good level of 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. The centre was seen to provide a wholesome and varied diet to residents that met their identified needs, and provide quality end of life care that respected individual's wishes, and was praised by family members.

Residents requiring end-of-life care received a caring service at this stage of life from staff who knew their needs. Staff were provided with appropriate training and supported by prompt access to palliative care services. Relatives gave positive feedback about the care given to their family members. However, some improvements were required regarding the care plans for people approaching end-

of-life, to provide clear guidance for the care to be provided, and to ensure the policy was fully implemented.

The nutrition and hydration needs of residents were met. Residents were provided with food which was varied and nutritious and respected their preferences. There was a good standard of nutritional assessment and monitoring and residents had very good access to general practitioners (GP) when required. Audits were carried out monthly to identify any residents who needed more support to maintain good nutrition and hydration levels. Feedback given to the inspector by residents and relatives was positive about the quality of meals and access to food and drink. However, some improvements were required to care plans to ensure they reflect individuals assessed needs around diet, including modified diets.

These matters are discussed further in the report and in the Action Plan at the end of the 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

Outstanding requirement(s) from previous inspection:
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Care planning, as it relates to end of life care and nutrition and hydration, was reviewed under this outcome. Minor non compliance as detailed under outcomes 14 and 15 were identified. Other aspects relating to this outcome were not reviewed during this inspection.

Judgement:
Non Compliant - Minor

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:

Residents received a good standard of end-of-life care, from staff who knew their needs. However, some improvement was needed in the care planning process to ensure records reflected individual choices and current needs when entering the end-of-life phase.

There were written and operational policies and protocols in place for end-of life care. It covered care planning, communication, and last offices. The policy also covered the need for individualised person-centred plans, but the review of the care plans showed that this part of the policy was not being fully implemented. Although the process of recording individuals wishes around end of life care plans for all residents had started, care plans were generic and would not fully guide practice. Staff spoken with were familiar with the policy, for example they knew about the need to support spirituality and care of the dying for different religions of people in the centre.

At the time of the inspection there were no residents who were receiving end of life care. Residents were seen to be receiving day to day care from staff who knew their individual needs. Staff spoken with were up to date with resident's current needs and some confirmed they had completed training about palliative care. The method of daily update included a staff handover meeting that took place at each shift change, and was lead by the nurse in charge of the shift that was ending. This included how residents were presenting and any needs they had. This could include an update on any residents who were at end of life.

The inspector read a number of care plans and found residents had basic end-of-life care plans in place, in the event that they became seriously unwell and were unable to articulate their wishes. The examples seen were using standard text, using the same information in each case, if these were personalised they would be more useful. They did not cover areas such as the resident's preference for place of death and how that could be facilitated. There was also a section of the care plan that covered spirituality, level of concern about the future, and recorded if there had been any discussion about resuscitation, and its outcome. Residents and relatives had signed their agreement to this in some of the examples seen.

For residents who were considered to be entering the end of life phase, care plans were in place that covered a wide range of areas, for example physical needs, pain

management, energy management, spiritual and psychological needs. However they did not provide clear detail about what needs had changed from the other sections of the care plan that had been written at an earlier date. Staff spoken with were clear that although wishes could be recorded in the care plan, any medical decisions would be made by clinical staff when necessary. The action for this issue is recorded under outcome 11, Health and Social Care Needs.

The person in charge had completed audits of care plans and identified this issue, and training was scheduled for the following day to cover what was expected in each care plan including the importance of dating and signing.

The inspector saw evidence of residents receiving services from allied health professionals, such as dietician, speech and language therapy, occupational therapy. The person in charge confirmed there was a dentist who completed checkups, and emergency treatment when needed, and examples were given of the treatment received. There was also evidence of regular review from the general practitioner (GP); this also included review of medication. Palliative care services were seen to have been in place for those who needed it in the past, and staff spoken with said the service was very supportive of residents in the centre.

Some staff had received training about palliative care. Staff feedback was positive about the training, a number commenting that it had made them think of residents in a more individual way. At the time of the inspection there was sufficient staff to meet the needs of the residents.

All religious and cultural practice was facilitated. Residents confirmed they were able to attend religious services in the centre, including Mass and Church of Ireland Services, and could access priests or other clergy when they wanted to see them. There was a room available for residents who wishes to be laid out at the centre, and leave for their funerals.

Family and friends were seen to be visiting relatives throughout the inspection, and made to feel very welcome. Those spoke with confirmed they were able to spend time with their relatives and receive food and drink as required during their visits and were always made to feel welcome. There were facilities available for visitors to make drinks and snacks for themselves and their relatives. Feedback in the questionnaires completed by relatives of those who had previously lived in the centre was positive about the support they and their relative received at end-of-life from the staff and the person in charge. The relatives who replied were positive about the care provided after their relative had passed away, one stated 'money could not pay for the care provided to my relative'.

Most of the bedrooms in the centre were single, however if there were no single rooms free, those in double rooms would not have the option of a single room at end of life.

Relatives confirmed they were able to stay through the night if they wished. Staff confirmed this could be with their relative, or in a vacant flat close to the centre. Arrangements were in place to return residents personal belongings at a time that suited the relatives. The person in charge confirmed that it was up to relatives when they pack

the residents belongings, or if they wished the staff to do this. Items were handed over using the resident's own suitcase, or a designated box for end of life.

Judgement:

Non Compliant - Minor

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:

Residents received food and drink at times and in sufficient quantities to meet their needs, and in line with their personal preferences. However care plans did not consistently reflect the practice or guidelines from allied professionals.

There was a policy on monitoring and documentation of nutritional intake that gave clear guidance to staff. The inspector observed that it was being implemented in practice. For example, nutritional screening was in place for all residents and intake records and modified diets for those where the need was identified. Staff spoken with were very clear in their role of monitoring residents for any sign of reduced intake of food or drink, and were able to explain what action they would take. Records seen by the inspector showed monitoring of intake/ output was being closely monitored for those who were not taking a full diet.

Monthly audits were being carried out for all residents' nutrition and hydration needs reviewing data over a 3 month period for any trends or longer term changes. The audits identified people risk of malnutrition and ensured that referrals had been made to allied health professionals as required, including occupational therapy. The audits provided a lot of information for the management team to check the practice in the centre against the policy and it also directed the practice of staff to ensure all individuals' needs were being met.

The inspector reviewed a number of care plans and supporting documents, such as speech and language therapy assessments. They were individual to the residents and included food preferences. Special diets for residents were recorded in most cases, however there was some inconsistency found in different aspects of the plans and some care plans did not reflect recent speech and language therapy assessment outcomes clearly. There were also examples where the detail recorded in the care plan was not sufficient to guide practice, for example to encourage a resident to take food before offering a supplement as advised by the dietician. The person in charge had already

identified care planning as an area that needed to be improved and training on writing and updating care plans was booked for the following day. The action for this issue is recorded under outcome 11, Health and Social Care Needs.

The care plans did show good evidence of monitoring residents, for example weight, body mass index and malnutrition screening. There was also clear evidence of action being taken where residents had a change that may show they were at risk of malnutrition. For example the general practitioner (GP) was called to review resident's health care needs and medication, and referrals to dietician, speech and language therapy and occupational therapist were made. Dental services were available, with checkups being offered and treatment where the need was identified for a resident.

Staff handovers at the beginning of the shift identified those who needed to be monitored, and staff spoken with were very clear of the needs of the individuals they were supporting. Some residents were seen to take nutritional supplements. These had been agreed with the general practitioner (GP) who had prescribed them, and then kept them under review. They were clearly recorded on the prescription records of residents.

The inspector observed the service of breakfast and the main meal to residents. Meals were seen to be properly prepared, cooked and served. Residents were seen to have good access to food and drink through the day including fresh drinking water. Residents confirmed that if they wanted something out of regular meal times it would be arranged for them, but they never felt the need to do this as drinks and snacks were offered regularly. Staff confirmed that they were able to access food for people when the kitchen staff were not there in the evenings and through the night. This included sandwiches and hot food if required.

All residents had their breakfast in their room, but the person in charge said people could eat in the dining room if they preferred. Residents were able to choose the time they wanted their breakfast, and it was usually served between 7.30 and 9.30. On the day of the inspection, some residents had had an early breakfast, around 7.30, and they confirmed this was their preference. The inspector saw that people were being supported to eat and drink in their rooms by staff who were offering assistance in a discreet and respectful way. Many people were sat up in bed, while others sat in a chair with a small table. Staffing levels reflected the needs of those who required assistance. Residents were eating a range of food including cereals and toast. Some residents were observed to have gone back to sleep following their breakfast, but when the inspector spoke to some later in the day they said this was their preference.

At lunch time most residents ate in the two separate dining rooms. It was served at 12.45pm. A small number of residents had their meal in their rooms if they chose or were resting. Support was seen to be appropriate to residents needs with staff supporting people sensitively and offering encouragement where it was needed, encouraging independence where possible. Some relatives chose to attend daily to support their relatives, and they were also offered food and drink. Kitchen staff plated up meals for individuals as they were needed and staff delivered it directly to the resident. The meal times were overseen by a member of the nursing staff.

The food was nicely presented and residents told the inspector it was very nice chicken that had been served on the day of the inspection. Modified diets and Liquidised meals were also well presented using crockery that kept the items separate. The meal was unhurried and provided opportunity for socialisation, with family joining the meal, some as visitors and others to support their relatives to eat.

Residents and relatives spoken to were very positive about the quality of the food, stating that they liked the food that was served, and that there was always a choice of what to have. For the residents who had dementia, staff were familiar with their preferences, but still always offered a choice, and had pictures they could use to show people. Staff also said they would always ask as some days people would be able to choose, and they never assumed they knew what residents wanted.

The dining room was light and well presented and was seen to be a very social area. There were a range of table arrangements, some for small groups of people, and some for larger groups. Tables were laid out with cutlery, condiments and napkins. There were also flowers on each table. Trays for people in their rooms were also well presented, with tea pots and milk for those who were able to manage them, so they could make the tea to their liking.

Staff had received training on nutrition and hydration via an online training resource. The training included guidance on dysphagia. Staff confirmed they had learned new information on the courses and were putting it in to practice, for example the importance of a good seating position to prevent choking.

There was access for residents or relatives to make their own drinks, and this was seen to be well used on the day of the inspection.

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:

Helen Lindsey
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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:	Glebe House Nursing Home
Centre ID:	ORG-0000039
Date of inspection:	24/06/2014
Date of response:	31/07/2014

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:

Care plans for end of life care and nutrition did not provide up to date information to guide practice.

Action Required:

Under Regulation 8 (2) (b) you are required to: Keep each residents care plan under formal review as required by the residents changing needs or circumstances and no less frequent than at 3-monthly intervals.

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

- Care plan review schedule has been revised to ensure that the person in charge and clinical nurse managers carry out full review of 4 care plans per week. This will ensure that all care plans are formally reviewed no less frequent than at 3 – monthly intervals.

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

- Staff training on care planning was carried out by the person in charge. These trainings will continue on regular basis.
- Staff are required to address deficiencies identified on their allocated care plans within 72 hours. The staff compliance will be closely followed up by the person in charge.
- The care plan for each resident has been reorganized to include reviews by dietician, SALT, physiotherapy and other members of multidisciplinary team. This new system will ensure that the recommendations, medical plans and decisions are reflected on specific care plans of residents.

Proposed Timescale: 15/08/2014

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 Care policy was not being fully implemented with regard to individualised person centred plans.

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:

- The person in charge will continue to train the staff in end of life care planning.
- The staff are instructed to consistently include in the residents care plan information such as residents specific wishes and choices ie. preference for place of death and how this could be facilitated. This information is included as part of assessment of activities of daily living.
- The person in charge will carry out audits of end of life care plans to ensure that the interventions and plans are specific for each resident and that any changes in their condition are clearly reflected in the care plans.

Proposed Timescale: 15/08/2014