

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St. Clare's Home
Centre ID:	OSV-0000517
Centre address:	Griffith Avenue, Glasnevin, Dublin 11.
Telephone number:	01 704 4200
Email address:	gmdnc@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Michelle Forde
Lead inspector:	Leone Ewings
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	39
Number of vacancies on the date of inspection:	1

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 the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 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: 10 July 2014 10:00 To: 10 July 2014 17:30

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 the provider and person in charge were provided with an information seminar. Providers and person in charge had received evidence-based guidance and undertook a self-assessment in relation to both outcomes prior to this inspection. The deputy person in charge and wider multidisciplinary team had judged that the centre was compliant in relation to end of life outcome and compliant in food and nutrition outcome. Residents confirmed their involvement and engagement with staff to ensure their wishes were respected on an ongoing basis.

On inspection the inspector reviewed policies, assessments, care plans, training records and the provider self-assessment tools relating to End of Life Care and Food and Nutrition submitted by the person in charge pre-inspection. The inspector met residents, relatives and staff and observed practice on inspection. St Clare's has a dining room on the ground floor for Roseview and a first floor dining room on Oakview. Overall residents were very satisfied with the mealtime experience and food choices available at the centre.

End-of-life care practices and outcomes for residents and relatives were found to be of a good standard. The End-of-life policy reflected practices and documentation was found to be person centered and informed/guided staff in this area. Feedback from relatives of residents who had experienced end of life care within the centre was very positive. Seven completed questionnaires had been received by the Authority and were reviewed prior to the inspection. Staff were commended for the kind, sensitive and caring approach. Some of the respondents had highlighted the need for more identified private facilities at the centre and this was communicated at the close of the inspection.

The requirements for improvement are outlined in relation to appropriate provision of a preference for a private room is addressed in the action plan at the end of this report.

The inspector also found that specific written information on services and supports available to relatives were offered to relatives following family meetings if appropriate and following the death of a loved one to further assist and guide them. A high standard of communication was evident from records of family meetings reviewed by the inspector and observations during the inspection process.

Feedback relating to access to single accommodation and provision of choice relating to place of death requires review particularly on Roseview where there is no single accommodation available.

Food and Nutrition outcomes and practices were of a very good standard. Residents spoken with confirmed this and mealtimes were observed to be a relaxed social occasion. The inspector observed lunch and teatime meal services. All residents' needs were met with regard to maintaining independence and appropriate assistance from staff when required with eating and drinking. A recommendation relating to promoting independent dining relating to self service of drinks on the tables was made to the person in charge.

From evidence gathered on inspection the inspector formed the view that the centre was in substantial compliance food and nutrition outcome, and required improvements in relation to in relation to end of life care relating to provision of private accommodation.

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 2013 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(s):

No actions were required from the previous inspection.

Findings:

There was an end of life care policy in place which reflected the care relatives said was provided to their relative during end of life care at the centre. The end of life care policy was last reviewed and dated as 4 February 2013. Staff spoken with had an understanding of the policy and implemented care accordingly which upheld the dignity and respected the autonomy of residents.

The end of life policy was not centre specific to this centre but also encompassed practice over the three designated centre on the campus. The end of life care provided to residents was to a 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. The centre and staff were seen to respect the individual residents' religious and cultural practices. Examples of this were discussed with the inspector in detail and confirmed by the respondents to the questionnaires.

Records and documentation such as assessments, care plans, end of life discussions and transfer details of the deceased remains were completed with individual guidance. These were reviewed by the inspector as part of the process and overall were found to be reflective of individual wishes of the residents. Written information on services and supports available to relatives after a death at the centre was available. However, the policy in place did not guide staff fully on documenting individual wishes relating to the place of death or on admission relating to availability of private rooms. Improvements relating to documenting residents wishes relating to privacy and private accommodation could be improved. The internal audit of death reviews which took place post each residents' passing were not fully linked into the policy improvements where necessary.

No resident was receiving end-of-life care at the time of inspection. Respondents to the relatives questionnaire had confirmed that a single room had been made available to some when required. Staff said residents were consulted and given the choice of where they would like to die. In practice and further to respondent's feedback, not all residents had full access with regard to being accommodated in private facilities, particularly on the ground floor. Feedback from relatives had been received by the Authority prior to inspection and informed the process, the centre had sent out 10 questionnaires and 7 of which had been returned to the Authority. Overall the feedback was very positive and rated the experience highly on the rating scales. Of this number three had highlighted the very positive care experience, but on reflection would have preferred additional privacy that private accommodation offered. This was discussed with the deputy person in charge and clinical nurse manager during the inspection and areas for improvement identified with regard to informing potential residents of Roseview of the absence of private accommodation at time of admission and documenting the wishes for end of life care to include this aspect relating to privacy and dignity with the residents individual wishes. Relatives confirmed the staff made available to them a good standard of emotional and practical supports. For example, refreshments and meals and relatives overnight accommodation was made available on the first floor (Oakview) if required. Private visiting areas and communal spaces/outside space were reported as used frequently. The individuals' right to refuse treatment was well documented.

Residents confirmed they had been asked about their preferences regarding end of life care and options available to them. 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 residents and staff with regard to individualised needs of each resident no resident had requested a return to their original home over the last number of years, and considered the centre as their home. The self assessment confirmed that no resident who had an end of life care plan in place had been transferred to acute services over the last two years. The person in charge

discussed the range of medical and nursing options available including staff with appropriate skills that had been trained for delivering sub cutaneous fluids and specialist continuous infusion devices for pain relief, which could be prescribed and administered. A high standard of consistent medical cover, and frequent review was evident from the medical records reviewed as part of this inspection.

The inspector confirmed with residents that they wished to stay at the centre and considered the centre their home. The inspector noted that 18 out of the 22 residents who had died in the past two years had died in the centre, and four in hospital further to transfer.

There was a visitor's room which had refreshments available, and all catering arrangements for visitors could be accommodated on site with snacks, tea, coffees and meals if required. There was no actual sleeping arrangements in place for relatives, but relatives were welcomed to stay in the residents own room. Relatives who completed questionnaires confirmed they were facilitated to stay with their loved one when they were dying, and records reviewed confirmed that family members were facilitated day or night to visit and spend time. 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 medical officers at the centre.

The centre had access to the community based palliative care team, and training had been facilitated by the team for nursing and care staff. The inspector was informed that referral and review from the team was provided whenever necessary, however, in practice the skills were available at the centre with regard to palliative care and use of equipment such as syringe drivers and pain management. In house expertise was available and three staff identified to the inspector had completed post graduate qualifications in palliative care. Training has taken place with regard to individualised end of life care.

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 yearly family meeting also took place (or more frequently as required) 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 general practitioner (GP) had decided that the resident was not for cardio pulmonary resuscitation (CPR) or active measures, but for all 'comfort' measures. In practice a review of residents transferred to hospital by the provider indicated that 13 residents had been transferred for acute care. The main reasons for transfer were not documented as for end of life care but for acute 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 and pastoral care worker. The Sacrament of the sick was also provided and the priest sought at the residents' request. A daily televised mass service was held each morning in the day room from the

local parish. Respondents confirmed the spiritual needs of deceased residents had been fully met in a sensitive manner. There was a clear process fully documented for returning possessions following a death.

Relatives stated that there were sufficient staff on duty at the time of their relatives death. One relative gave an example of how they felt the staff were part of the family at the time of death and had taken comfort that their relative had died without pain and in a comfortable environment. Another respondent confirmed that to them the staff acted in such a professional but compassionate manner that "it was like staff had lost a relative".

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, and this was found to be well documented. A specially arranged property bag had been available for use for return of personal possessions. Information was available to relatives on the death of a loved one, and booklets were available in the entrance foyer.

Education records showed staff had received relevant 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. Three monthly end of life interest groups met to review service feedback and make improvements. The centre operated a policy of reviewing each resident's death, and allowed for staff to inform the process and examine what went well, and any areas for improvement or further training needs identified.

The requirements for improvement are outlined in the action plan.

Judgment:

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(s):

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. Snacks and refreshments were offered throughout the day at regular intervals and available for residents who needed additional nutritious snacks and found it difficult to sit down for scheduled mealtimes.

The policy on nutrition and hydration/dysphagia care had been kept under review, most recently May 2012, and it was due for review in May 2014 (documentation was submitted as part of provider self assessment during March 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 it was fully implemented. 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, with regards to menu planning and provision of each individual residents' dietary needs.

There was also a policy on guidelines for care of residents with Percutaneous Endoscopic Gastrostomy (PEG) last reviewed on 31 January 2013. There were no residents receiving PEG feed on this inspection. A number of residents had been prescribed supplementary food and drinks. The inspector met with the dietician who was visiting to assess and review residents at the centre and confirmed the referral process. The self assessment document outlined improvements which had taken place further to a study completed by dietetic students during 2013; the use of clothes protectors had ceased and alternatives were now in place, and staff were offering meals visually to residents with cognitive impairment in order to facilitate choice at each meal in line with resident preferences.

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. The appropriate equipment to meet the resident's needs such as modified cutlery and cups were found to be available for use, and staff promoted independent dining. For example, one member of staff in the dining room verbally described food choices throughout the meal to a resident with a visual impairment, and the resident was seen to enjoy each course of their meal.

The inspector observed lunch at 12.30hrs and tea at 16.30hrs being served to the residents. Residents confirmed they could choose where they wanted to eat. Residents had access to two separate dining rooms, which was proximal to the kitchen. Catering staff prepared meals from the four week summer rolling menu. A small number of residents ate their meals in their own rooms. There was a hot food choice of available for lunch with a choice of potatoes and vegetables. Catering staff were aware of each resident's likes/dislikes and needs. The dining list outlined any resident who required assistance 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 choices and service. Residents could view the food at mealtimes prior to making a choice. The lunch was prepared and cooked in the kitchen by the chef and kitchen assistants and came plated up.

The choices available to residents were displayed on a menu on a blackboard on the wall in the dining areas. Residents chose meals on the day (late morning) and the resident was also asked their preferred choice/option again prior to the meal being served. Residents who required a minced or smooth pureed diet also received a choice of meals, the menu which was delivered and was consistent with the published menu given to the inspector. Vegetarian options were available to the residents; there were no residents who required this option.

The catering staff had a good knowledge of those on special diets such as weight reducing, 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 modified food consistency. Details of fortification of foods 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 with all required condiments and cutlery to meet the residents' individual needs in an attractive manner. 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. Adequate 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 the residents' meeting. A number of examples of resident feedback were given to the inspector. The inspector was told that any food service was reviewed and feedback from residents informed menu planning.

The tea time service was of a similar service provision to the lunch time. Choices included chicken salad, eggs and every day a special was offered at tea time. Further to a review of the four 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, 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. Weight loss and difficulty maintaining weight was monitored closely. 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 medical guidance. The inspector noted a high standard of vigilance and action relating to any weight loss and appropriate actions to address including specialist assessment and review by the multi-disciplinary team. 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 of a high standard, with clear documentation of assessment and regular reviews.

Documentation confirmed that residents' assessments were updated for new admissions and daily when required using a paper system. 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. Cold drinks and snacks which were available at all times to residents. Residents confirmed to the inspector that family occasions and birthdays were celebrated at the centre. Pictorial menus were not evident at the time of this inspection, but provision of choice was confirmed by observation of staff interaction and communication during the meal services. Staff were clearly seen offering visually both options for each course to residents with cognition difficulties which aided choice for the resident.

Judgment:
Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

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Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	St. Clare's Home
Centre ID:	OSV-0000517
Date of inspection:	10/07/2014
Date of response:	26/08/2014

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 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:

All residents did not have access to private accommodation and the wishes were not facilitated, or wishes relating to privacy requirements were not addressed for all residents or their representatives.

Action Required:

Under Regulation 13(1)(d) you are required to: Where the resident approaching end of life indicates a preference as to his or her location (for example a preference to return home or for a private room), facilitate such preference in so far as is reasonably practicable.

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

A number of options are being explored to ensure that residents will have access to private accommodation should they wish when approaching end of life.

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

Proposed Timescale: 30/11/2014