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

Centre name:	Raheny Community Nursing Unit
Centre ID:	OSV-0000704
Centre address:	Harmonstown Road, Raheny, Dublin 5.
Telephone number:	01 850 5600
Email address:	rcnu@beaumont.ie
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Beaumont Hospital
Provider Nominee:	Mary Keogh
Lead inspector:	Leone Ewings
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	100
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 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:	To:
12 August 2014 11:00	12 August 2014 19:00

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 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 person in charge and wider multidisciplinary team had judged that minor non-compliances in relation to both outcomes. Steps had been taken to address these non-compliances prior to this inspection by the provider and the person in charge.

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. Overall residents were very satisfied with the mealtime experience and food choices available to them at the centre.

End-of-life care practices and outcomes for residents and relatives were found to be evidence based and of a good standard. The End-of-life policy reflected practice 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. Feedback relating to end of life care at the designated centre was very positive, and well rated by respondents with a high level of satisfaction. Five completed questionnaires had been received by the Authority and were reviewed prior to the inspection. Staff were commended for their kind, sensitive and compassionate approach. Some of the respondents had highlighted the importance of private accommodation and good communication with staff throughout

the experience. Feedback from respondents was communicated to the provider and person in charge at the close of the inspection. Since the last inspection the person in charge has improved the documentation used to assess and plan for care delivery and meet the changing needs of the resident's end of life care experience.

A good standard of communication was evident from records of family meetings reviewed by the inspector and observations during the inspection process. However, improvements were required relating to records of end of life assessment and provision of care planning to meet the changing needs. Provision by the person in charge to improve this was already in place at the time of this inspection.

Overall food and Nutrition outcomes and practices were found to be of a good standard. Residents spoken with confirmed this and mealtimes were observed to be a relaxed social occasion. Improvements had taken place since the last inspection relating to provision of additional dining spaces, and use of air conditioning in the main dining areas to maintain a comfortable room temperature. The inspector observed lunch and teatime meal services, and the provision of additional snacks and drinks throughout the day. All residents' needs were met with regard to maintaining independence and appropriate assistance from staff when required with eating and drinking.

From evidence gathered on inspection the inspector formed the view that the designated centre was substantially compliant relating to both outcomes.

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 a revised end of life care policy in place which reflected the care relatives said was provided to their relatives in the centre. The end of life care policy had been updated and reviewed as required from the last inspection and was dated as July 2014, and was found to be centre specific to this centre. Staff spoken with had an understanding of the policy and implemented care accordingly. The inspector found that the policy in place supported and upheld the dignity and individual needs of residents and their relatives, by guiding staff in a evidence based way.

Respondents to questionnaires confirmed that 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.

Records and documentation such as assessments, care plans, end of life discussions and transfer details of the deceased remains were completed by staff. Written information on services and supports available to relatives was available to relatives after a death at the centre. However, the inspector noted further to a review of two deceased residents records that improvements were required with regard to documentation of assessment and care planning which was not found to be completed by nursing staff. The person in charge informed the inspector that improvements in documentation had taken place over the last year and a new template had been chosen, and the use of this to assess and plan for care had now commenced. Examples, of this revised documentation were reviewed by the inspector and found to be adequate. A discussion was held with the person in charge about the overall plans for training and full implementation of the revised documentation to improve records in this regard.

No resident was receiving end-of-life care at the time of inspection. Staff said residents were consulted and given the choice of where they would like to spend their last days. The centre had sent out ten questionnaires to relatives of deceased residents, five of which had been returned and this feedback had been received by the Authority prior to inspection. Of this number all had highlighted the positive care experience, one

respondent had referenced the positive outcome that a resident had been able to return to the centre from acute care setting for end of life care at the centre.

Residents confirmed they were 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. 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 who had been trained for delivering antibiotics intravenously and in addition sub-cutaneous fluids which could be prescribed and administered at the centre. A high standard of consistent medical cover was evident from the residents' 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 56 out of the 62 residents who had died in the past two years had died in the centre. Access to the palliative care team was confirmed based at the hospital and in the local community for support advice and training.

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. Overnight facilities were in place for relatives, and 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. Tea and coffee making facilities were also freely available from catering staff, 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 overall medical care provided by the medical staff at the centre.

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. Family meetings also took place three monthly (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 medical team 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 23 residents were transferred for acute care. The main reasons for transfer were related to treatments required for infections, diagnostic procedure, 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. A policy to support anticipatory prescribing designed to enable prompt symptom relief was in place.

Residents' religious needs were facilitated by their own spiritual advisers and a pastoral

care worker located in the nearby convent on site. A new large oratory/quiet space had been created at the centre which was available to residents and relatives since the time of the last inspection. The Sacrament of the sick was also provided each month, although in practice the relatives of residents organised and facilitated this as there were no formal arrangements in place for an on-call Roman Catholic or other beliefs established. However, a quality of life survey conducted in October 2013, confirmed that residents spiritual and psychological care and individual beliefs were respected by staff. Results of this survey were disseminated to residents and relatives.

Relatives stated that there were sufficient staff on duty at the time of their relatives death.

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 well documented. A specially arranged property bag was available for the 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 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.

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

Findings:
The inspector was satisfied that measures had been put in place following the last inspection to mitigate risks associated with increased room temperatures. The dining experience had improved by provision of additional dining space for residents and had been sufficiently addressed by the provider. Room temperatures were kept within an acceptable level for residents by provision of air conditioning units and adequate ventilation. The large activities room upstairs and sitting room downstairs were used as extra dining areas at mealtimes to accommodate the residents who wished to dine with others. However, a large number of residents were found to eat their meals in their own rooms, this was found to be their own choice and catering staff were knowledgeable

about their dining choices and provision of individual needs.

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. All residents had choices of meal at lunch and tea time and the appropriate assistive equipment to meet the resident's needs was found to be available.

The policy on food and nutrition had been reviewed further to the provider self assessment, most recently in June 2014. There was also a policy on guidelines for care of residents with Percutaneous Endoscopic Gastrostomy (PEG). The policy reviewed 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.

Residents had access to fresh drinking water, the ice machine 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 drinking water by their bed which staff renewed daily. Snacks were available and served throughout the day. For example, mid afternoon small clear containers of washed and prepared fruits were available and offered with drinks. As a result of the provider self assessment improvements had been identified with regard to food choices at supper times and menus adjusted accordingly. An audit relating to access to call bells and drinks had taken place since the last inspection and this had been completed by the clinical nurse manager.

The inspector observed lunch and tea being served to the residents. Residents confirmed they could choose where they wanted to eat. The choices available were consistent with the published menus, which had been reviewed by the dietetic department for nutritional content and variety and choice. Some residents chose to have their meals served in bed or by their bed. Catering staff prepared and presented trays with all requirements for each individual resident. Catering staff knew the residents likes/dislikes and needs and offered choices accordingly. For example, those that did not have and extended ability to sit at mealtimes were offered and finger type foods and snacks. Residents spoken with told the inspector that they enjoyed the lunch and tea served to them.

At lunch time the choice was displayed on a board. Residents completed a meal choice form the day previous and the resident was asked their preferred choice again prior to the meal been served. Lunch was served by catering staff from a bain-marie in the dining rooms. Residents could also view the food prior to making a choice. The lunch was prepared and cooked in the main kitchen of the proximal to the front door of the centre. The choice of food displayed on the menus was reflected in all of the four food

service areas. The menu offered a choice of three hot main courses, and four vegetables. Residents who required a minced or smooth pureed diet also had choices available which were clearly outlined on the detailed four week rolling menu.

The catering and care 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. The inspector confirmed that 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. The inspector saw that catering staff had all of this information available to them in each kitchen servery. Each area had detailed information on each residents eating and drinking requirements informed by specialist assessment and review from speech and language therapy and dietetics. An audit had taken place of residents on modified therapeutic diets to evaluate the implementation of care delivery. This information was used to inform future training requirements. The inspector was satisfied that staff demonstrated competency relating to the provision of safe and dignified mealtime experience.

The dining room tables were set with linen tablecloths and all required condiments and cutlery to meet the residents' individual needs. The two main dining rooms were seen to be less busy than at the time of the last inspection. 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 all four areas. They were observed encouraging and promoting residents to be independent in a sensitive manner. The person in charge informed the inspector that plate pals were in place at the centre and had been matched to a small number of residents. However, on the day of the inspection there were no volunteer plate pals at the centre.

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 monthly residents' meeting.

Clinical documentation was of a good standard. Assessments, care plans and nursing evaluation notes were reviewed. Residents were risk assessed on admission and reviewed three-monthly with a validated assessment tool for food and nutrition, skin integrity and oral hygiene assessment tool. 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 instructions. The inspector noted that a small number of oral assessment tools had not been fully completed or dated with regard to dental assessment section. The person in charge agreed to review completion of this assessment.

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. A dietician and a speech and language therapist was available to assess resident's requirements the centre. Both specialists had been involved in assessing all residents and providing education and support to the nursing, care and catering staff. Education records showed staff had received training in several areas in relation to food and nutrition, and provided assistance in a manner which respected each resident's dignity.

A policy on protecting resident mealtimes had been developed. Medication was seen to be administered during the mealtime to residents in the two main dining areas by nursing staff. The person in charge told the inspector that some residents liked to have their medication before meals and this was accommodated.

The inspector recommends that the provider and person in charge continue to review and monitor and develop current provision to ensure that the changing needs of all residents are accommodated comfortably.

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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