# Health Information and Quality Authority

## Regulation Directorate

### Compliance Monitoring Inspection report

**Designated Centres under Health Act 2007, as amended**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St. Theresa’s Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0000434</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Dublin Road, Thurles, Tipperary.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>0504 22246</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:st.theresasnursinghome@gmail.com">st.theresasnursinghome@gmail.com</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Camillus Healthcare Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Ann Fitzpatrick</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Ann Fitzpatrick</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Gemma O'Flynn</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on</td>
<td>35</td>
</tr>
<tr>
<td>the date of inspection:</td>
<td></td>
</tr>
<tr>
<td>Number of vacancies on</td>
<td>6</td>
</tr>
<tr>
<td>the date of inspection:</td>
<td></td>
</tr>
</tbody>
</table>
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: 16 April 2014 07:45 To: 16 April 2014 17:00

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

<table>
<thead>
<tr>
<th>Outcome 11: Health and Social Care Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 14: End of Life Care</td>
</tr>
<tr>
<td>Outcome 15: Food and Nutrition</td>
</tr>
</tbody>
</table>

Summary of findings from this inspection

This report sets out the findings of a thematic inspection which focused on two specific outcomes, End of Life Care and Nutrition. In preparation of this inspection, providers attended an information seminar; received evidence based guidance and completed a self-assessment in both outcomes to determine their level of compliance. As a result of completing the self assessment questionnaire, the provider had determined that the centre was compliant in both outcomes.

Prior to the onsite inspection, the inspector reviewed the self assessment questionnaires submitted by the provider. On the day of the inspection, the inspector reviewed the centre's policies pertaining to both outcomes and met with residents and staff and observed practice of the staff on the day. The inspector also reviewed survey questionnaires submitted by relatives of residents who had passed away in the centre. All questionnaires received indicated a high level of satisfaction with the care that these relatives' loved ones had received in the centre at the end of their life.

On the day of the inspection there were 28 residents in the centre and one resident in hospital. The inspector found evidence of good practice led by a high standard of nursing care within both outcomes and found that the needs of residents' end of life care and nutritional needs were substantially met. The inspector found that in general, care plan documentation required some further development in order to fully reflect the good, person centred care that was being provided to the residents.
**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

**Judgement:**
Non Compliant - Minor

**Findings:**
The inspector found that the residents' healthcare needs were met to a high standard but the good practice that was undertaken in relation to the comprehensive assessment of needs was not always reflected in the residents' care plans.

Residents had been assessed to identify their individual needs and choices. A range of nursing assessments were completed on admission and were updated monthly which included mouth-care assessments, dysphagia and choking assessment and hydration assessments. Whilst these were complete for each chart reviewed, the inspector found that they did not adequately inform the development of the residents' care plans. For example, one care plan stated that an intake chart should be used if necessary, however, the inspector found that the resident's need for an intake chart should have been clearly determined following their assessment prior to completion of the care plan. The person in charge confirmed that the practice in the centre was for the care plan to inform the need for an assessment to take place.

The inspector found that nutritional care plans were in place and were reviewed regularly but the inspector found that these required further elaboration to reflect the person centred care that was being delivered. Whilst the care plans gave adequate information regarding abilities and likes and dislikes, the form was a tick box document and did not expand on the resident's needs, preferences and routines in a sufficient manner.

Upon reviewing the notes of a resident who required specific nursing interventions to monitor a condition that was controlled by diet, it was evident that these interventions were being completed as required. However, the documentation for the frequency of the monitoring interventions and the information on acceptable parameters to guide
consistent nursing practice was not clearly set out in the care plan. There was written evidence that residents/relatives had been involved in the development and review of their care plans. However, there was little evidence that the review of the care plan involved a formal evaluation of the current plan in place.

**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

**Judgement:**
Compliant

**Findings:**
The inspector found that overall the end of life care practices in the centre were of a high standard and were considered to be an important part of the service provided in the centre.

There was a comprehensive end of life policy in place, which had been recently reviewed and gave good guidance to staff on the procedures to follow before, during and after death. There was a system in place to ensure that staff read and were familiar with the policy and staff with whom the inspector spoke confirmed this.

Care practices and facilities were in place to enable the resident to receive care in a way that met their individual needs and wishes and respected their dignity and autonomy. An advanced end of life care plan had recently been undertaken for most residents and nursing staff confirmed that the documentation for all residents was nearing completion. These plans set out an opportunity for residents to identify their preferences at their end of life. This included important things they would like their family to know and who they would like to be with them in their final days. Whilst these were completed in good detail, the inspector reviewed a plan for a resident with a cognitive impairment that required further development. This was discussed with the person in charge on the day and she was aware of this and told the inspector of the plans in place to complete this.

The inspector spoke with a sample of residents who told inspectors that they were involved in their care and expressed that they had the opportunity to discuss their future wishes with staff.

The inspector reviewed care plans for residents near end of life and recently deceased. Whilst it was evident that a very high standard of end of life care was delivered to residents, the inspector formed the view that care plans did not fully direct the care provided. For example, one care plan stated assist with activities of daily living as necessary; the inspector found that more explicit information regarding the level of assistance required would ensure consistency in the level of care provided. It was clear that the resident and/or their representative was involved and consulted in regards to
the end of life care.

There were arrangements in place to avoid unnecessary transfer of residents to the acute care setting, for example through the administration of sub-cutaneous fluids where necessary. Where a resident refused care, this was respected and clearly documented.

Staff were supervised appropriate to their experience and there was evidence of training in 'palliative care approach' delivered to staff. On the day of inspection, the inspector observed sufficient numbers of staff on duty and saw that the care and interactions provided was respectful and unhurried. Staff told inspectors of the end of life symbol that was displayed in the office if a resident was nearing end of life, to remind staff to ensure the environment was kept calm and peaceful.

Religious and cultural practices were facilitated to a high standard. Religious clergymen visited the centre frequently and were seen to visit the centre on the day of the inspection. There was an inter-cultural guide available to staff to further guide them in delivering appropriate care and staff with whom the inspector spoke were aware of this document. The person in charge spoke of services that had been held in house for residents where appropriate.

Family and friends were facilitated to be with the resident in their final days. The centre had a policy of non restrictive visiting times and a welcoming visitor's room. When available, a bed was provided for those who wished to stay overnight in the centre with their loved one. Relative surveys reviewed by the inspector confirmed that family/friends were offered the opportunity to stay overnight.

Residents had a choice as to their place of death where possible. If available a single room was designated for the use of the resident and staff nurses told the inspector that where a resident indicated that their preference was to die at home, this would be facilitated so far as practicable.

There were strong links with the local palliative care team. Records reviewed by the inspector confirmed the involvement of the palliative care team when required. There was no resident in the centre requiring that service at the time of inspection.

There were arrangements in place to ensure respect was shown for the remains of a deceased resident. Staff spoke of a specific 'end of life case' in the centre that contained specific items to ensure the transition between life and death occurred with dignity such as specific bedding. Staff spoke of how they carried out a 'guard of honour' for each resident's final journey from the nursing home. There was also contact details for local undertakers and information regarding humanist services and environmental services.

There were arrangements to liaise with family and undertakers regarding the arrangements for the removal of the resident's remains from the centre. A framed photograph of the recently deceased resident, along with information regarding the funeral arrangements, was displayed in the centre's reception area. The centre had a plethora of information available for family of the deceased in regards to coping with bereavement and useful information in regards to registering deaths in Ireland. There
was arrangements in place for the return of residents' belongings and staff were knowledgeable of the specific end of life possessions bags that the centre used.

Staff with whom the inspector spoke said that they were supported by the team in the centre after the death of resident. The inspector was told by the person in charge that where possible, staff were facilitated to attend the removal / funeral mass of a resident.

**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

**Judgement:**
Compliant

**Findings:**
Overall, the inspector found that the nutritional needs of the residents were met to a high standard.

There was a robust policy in place to guide staff in the monitoring and documentation of nutritional intake which was implemented in practice. There was comprehensive risk assessments completed on a monthly basis for all residents such as hydration assessments, oral assessment and nutritional status assessments. The inspector noted that these were up to date for each resident for whom a file was reviewed. However, it was not evident that these assessments informed the development of the care plan. Monthly weights were recorded for all residents and staff were able to discuss what would give them cause for concern if there were any changes noted and what they would do in such a situation.

Care plans were in place for residents regarding nutrition, however, the inspector found that these required some further development to ensure that they were person centred and gave sufficient guidance to staff. This is discussed in more detail in outcome 11.

Resident records showed that they had access to allied health professionals such as speech and language therapist, dietician, dentist and GP services. Appointment records were maintained and outcomes of the appointments were clearly recorded and action was taken where appropriate. The needs of residents with specific dietary requirements were clearly communicated to the kitchen staff. Charts were maintained in the kitchen identifying those residents and a system was in operation to ensure that residents received meals that had been prepared for their specific need. Kitchen staff were knowledgeable of residents' needs and there was lots of information on the kitchen notice board pertaining to special diets such as information about low or high potassium foods and diets that required modified consistency foods. Where thickening agents were required for some food / drinks, staff with whom the inspector spoke, including the
kitchen staff were able to demonstrate sound knowledge on how to do this appropriately.

There was access to fluids throughout the day and staff were seen administering fluids to residents at regular intervals.

The dining room was pleasant and the tables were set in an attractive manner. Breakfast was seen to be a leisurely affair as was lunch. Some residents chose to have their meals in their bedrooms or sitting room. Residents were assisted to eat and drink in a sensitive manner and all interactions were seen to be discreet and respectful and there was music playing in the background at meal times. Residents who required assistance were afforded ample time to take their meal and were asked questions such as their satisfaction with the temperature of the food and whether or not they had had enough. Gentle encouragement and prompts were offered as appropriate and respect for the resident's choice was apparent. There was sufficient staff on duty to meet the needs of the residents on the day of the inspection and training records showed that they had received training in nutrition matters from both an external provider and also in house. Staff with whom the inspector spoke were knowledgeable about the nutritional needs of the residents.

Whilst residents did not have access to equipment to prepare their own food, snacks were available throughout the day and night. Food was available in sufficient quantities and appeared to be nutritious, wholesome and presented in an appetising manner. Food was available at any time that suited the resident and this was confirmed by residents themselves and via surveys that a number of residents completed on the day.

A four weekly menu was in rotation in the nursing home and the options on the day corresponded with the menu for that day. There was a blackboard in the reception area that informed residents of what the choices were for lunch and dinner and there was a system in place to ensure that residents had a choice of foods or could have something of their own choosing.

Resident meeting minutes showed that the subject of meals was addressed with the residents on a regular basis and residents were given the opportunity to express their satisfaction or dissatisfaction with the meals on offer. To date there had been no formal audit of the nutrition service, this was discussed with the person in charge on the day and she told the inspector that she would be putting a system of audit in place.
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 the residents, relatives, and staff during the inspection.

Report Compiled by:

Gemma O’Flynn
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider's response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St. Theresa's Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0000434</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>16/04/2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>20/05/2014</td>
</tr>
</tbody>
</table>

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 did not fully set out the residents’ needs in a way that would guide consistent care. The documentation of nutritional care plans was not fully person centred.

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.

Please state the actions you have taken or are planning to take:
All care plans that are currently in place have been reviewed to fully set out the Residents needs and include the practices that are in place. The nutritional care plans that were in place have been amended to reflect the person centred care that is in

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

| Proposed Timescale: 20/05/2014 |  |