<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Seanchara Community Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0000515</td>
</tr>
<tr>
<td>Centre address:</td>
<td>St. Canice's Road, Glasnevin, Dublin 11.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 704 4400</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:gmdnc@hse.ie">gmdnc@hse.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>The Health Service Executive</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Michelle Forde</td>
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<tr>
<td>Person in charge:</td>
<td>Mary Flanagan</td>
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<tr>
<td>Lead inspector:</td>
<td>Leone Ewings</td>
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<tr>
<td>Support inspector(s):</td>
<td>None</td>
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<tr>
<td>Type of inspection</td>
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<td>Number of vacancies on the date of inspection:</td>
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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: 25 June 2014 08:30
To: 25 June 2014 17:30

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

<table>
<thead>
<tr>
<th>Outcome 14: End of Life Care</th>
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<td>Outcome 15: Food and Nutrition</td>
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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 the inspection the provider and person in charge were provided with an information seminar, had received evidence-based guidance and undertook a self-assessment in relation to both outcomes. The deputy person in charge and wider multidisciplinary team had judged that the centre was complaint in relation to end of life outcome and compliant in food and nutrition outcome.

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 the day of inspection the inspector observed practice from a catering perspective in the west side of Seanchara which has it's own dining room and is separate to east side facilities which are on the other side of the designated centre.

End-of-life care practices and outcomes for residents and relatives were found to be of a good standard. End-of-life policy reflected practices and documentation was found to be of a high standard and person centred in its content. Feedback from relatives of residents who had died within the centre was very positive overall. Eight of the ten questionnaires had been received by the Authority and were reviewed prior to the inspection. Staff were commended for the kind, sensitive and friendly manner in which they treated each resident and good communication practice. Particular reference was made to the ‘dignity’, ‘compassion’ and ‘humanity’ of the staff in how they cared for residents and relatives at end of life. The inspector noted a well managed very active complimentary therapy service which provided additional comfort, support and relaxation to residents who wished to avail of this service.
Food and Nutrition outcomes and practices were also of a very good standard. Residents spoken with confirmed this and mealtimes on west side of Seanchara were observed to be a social occasion. The inspector observed the breakfast and lunch time meal services. All residents’ needs were met with regard to maintaining independence and appropriate assistance from staff when required with eating and drinking. Modified dietary requirements were readily available and review by multidisciplinary staff such as dietetics, speech and language and occupational therapy was available on site.

From evidence gathered on inspection the inspector formed the view that Seanchara was in substantial compliance in relation to end of life, and food and nutrition outcomes. A recommendation was made in relation to provision of a small table in the dining area to accommodate any resident who may wish to dine alone.
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 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:
The end-of-life care provided to residents at Seanchara was to a high standard. The provider self assessment and review was of substantial compliance in the area of end of life care. There was a written policy for end-of-life care in place which reflected the care relatives said was provided to their dying relative in the centre. The policy was up to date, centre specific and staff members were involved with review of the policy and the most recent review was in February 2014. Staff spoken with had an understanding of the policy and implemented care accordingly which upheld the dignity and respected the autonomy of residents. Specific details regarding actions following a sudden death were clear and guided staff. Residents property and personal belongings were documented and return of any property was clearly recorded in the residents records.

The inspector saw evidence that residents received end of life care which met their physical, emotional, social and spiritual needs and respected their dignity and autonomy. Respondents on a number of occasions praised the ‘humanity’ of staff caring for their relatives. Records and documentation such as assessments, care plans, end of life discussions held were completed with residents and relatives using a person centred approach with individual wishes well documented. A complimentary therapy service was integral to the comfort measures provided and the outcomes were well documented. Services included massage, relaxation and reflexology for residents who expressed an interest and were the planned care was appropriate.

Written information on services and supports available to relatives was available to relatives following family meetings and were offered after a death at the centre. Records reviewed reflected the care delivery and communication with resident and family to a high standard. Care plans for end of life care were in place for each resident, and information was clearly communicated in the resident records reviewed. For example, one resident had particular requirements with regard to place of burial and this was clearly documented in a series of letters and in the care plan to inform and guide staff. This was also confirmed further to a review of responses from relatives questionnaires and discussion with residents at the centre. 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 die. In practice all residents had had their wishes respected with regard to staying at the centre rather than a transfer to acute services for end of life care. Feedback from relatives had been received by the Authority prior to inspection and informed the process, the centre had sent out 10 questionnaires and at the time of the inspection 8 had been returned, which were reviewed by the inspector. The responses were very positive and satisfied with the end of life care received by their relative and supports in place for relatives and friends at the centre.

Residents were remembered on an annual service during the month of November and a pastoral care worker was available on a regular basis on site to provider support in spiritual matters. Individual requirements were respected and facilitated by staff at the centre. The inspector was satisfied that the deceased spiritual needs were met to date and relatives confirmed this in questionnaires returned. Responses received on questionnaires highlighted good communication by staff as a positive aspect of their experiences, during the end of life care experience.

Residents confirmed they were asked about their preferences regarding end of life care and options available to them. The end of life self assessment document stated that return home was not an option. However, on further evaluation and discussion with resident and review of relatives' questionnaires there was evidence that returning home was not always feasible, but was explored and discussed if raised by the resident. 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. Further to discussion with staff with regard to individualised needs of each resident the inspector was informed that no resident had requested a return to their original home over the last two years. 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 which could be prescribed and administered, and evidence that a nurse prescriber had been involved with the day to day care of residents. A high standard of consistent and regular medical cover was evident from the medical records reviewed as part of this inspection. Three monthly communication and family meetings were integral to the overall purpose and ethos of the centre and were well documented.

The inspector confirmed with residents that they wished to stay at the centre and considered the centre their home. The inspector noted that 24 out of the 25 residents who had died in the past two years had died in the centre. A number of residents' occupied shared bedroom and improvements at the premises to provide additional private accommodation is planned by the provider. However, relatives confirmed that transfer to a private single room had taken place when available for end of life care. Another respondent to the relatives' questionnaire had noted that transfer to a private room had been facilitated. Other relatives confirmed that a single room had been made available when required, although one respondent felt the room was a little small in their opinion.
There was a dining 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 a visitors room also in place for relatives, with facilities if relatives wished to stay over. 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. Tea and coffee making facilities were also freely available, and access to outdoor space and seating on the premises. Feedback received from relatives stated that the end-of-life care provided was 'excellent' 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 management completed an end of life review for each resident who had died at the centre, where feedback was sought on the staff's experience and views on each resident's end of life care. Evaluation of meeting the residents care needs, spiritual and emotional needs was evaluated and any areas for improvement were shared and actioned. End of life interest groups met on a quarterly basis, and the end of life co-ordinator if responsible for delivering training and development on end of life. For example, on the day of the inspection a syringe driver workshop took place for staff. A comprehensive training schedule was submitted with the provider self-assessment and evidence of multi-disciplinary involvement on a consistent basis confirmed and observed on inspection.

On the day of the inspection there were sufficient staff and respondents confirmed that was the case. One respondent commented that in their opinion additional staff should be provided for the last hours of a residents life, and also confirmed that they had been very satisfied and all care needs had been met in this regard.

**Judgement:**
Compliant

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### Outcome 15: Food and Nutrition

*Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.*

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
The inspector 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 all mealtimes. Snacks and refreshments were also offered throughout the day at regular intervals and
available for residents who needed additional nutritious snacks. The inspector observed
the breakfast and lunch service on the day of the inspection and observed a friendly and
individual service from catering, care and nursing staff involved.

The policy on food and nutrition had been created in 2009 and updated within the last
two years. It was robust and provided clear guidance to staff on how to care for
residents’ nutritional and hydration needs. The inspector saw that 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 it’s content and of
their role in ensuring residents’ nutritional and hydration needs were met, with regards
to menu planning and provision of each resident’s dietary needs.

The dining list was reviewed which contained relevant and up to date information was in
place for each resident for the catering staff. This information had input and updates
twice weekly from the dietician and speech and language therapist, with regard to
therapeutic and modified consistency diets, thickened fluids and any special requests
such as portion size and fortified milk and food likes and dislikes of each individual
resident. The information was located on a computer drive shared between the dietician,
speech and language therapist and catering managers to ensure efficient and effective
communication between staff.

There was also a policy on guidelines for care of residents with Percutaneous
Endoscopic Gastrostomy (PEG). There were no residents receiving PEG feeding at the
time of this inspection. A small number of residents had been prescribed supplementary
food and drinks, which were administered by nursing staff. 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 residents stated they were individually offered a drink between meals also.
Appropriate equipment was available to meet the resident’s needs, such as modified
cutlery and equipment for thickening fluids. The inspector recommends that the use of
over bed tables in the dining room be reviewed and consideration be given to provision
of a small table for those who may wish to dine alone.

Residents confirmed they could choose where they wanted to eat and choices available
to them. Residents had access to a dining room on west side, which was close to the
kitchen. Catering staff, prepared meals from the menu and catering staff used a trolley
to bring food from the kitchen to the dining room, and smaller numbers eating in their
meals in their own rooms. Breakfast was served to each resident by their bedside with a
good choice of hot and cold foods, including porridge, cereal, fruit, yogurt, juices or a
cooked breakfast. There was a table also set in the dining room if required. The cater
ning staff delivering residents' breakfast knew the residents likes/dislikes and needs, she
served breakfast then returned to see if anyone required more hot beverages or any
assistance with breakfast. For lunch here was a choice of pork stew or chicken with a
choice of potatoes and vegetables. Residents spoken with told the inspector that they
enjoyed the food service. The food service was well presented hot and tasty. The lunch
was prepared and cooked in the kitchen by the chef and kitchen assistants and came
plated up. Appropriate assistance was provided to each resident in the dining room or
their own rooms.
The food choices available to residents were displayed on a chalk board in the dining area and the inspector noted that the food offered was consistent with the published menu. Residents completed a meal choice form the day previous and the resident was asked their preferred choice again prior to the meal been served. Residents who required a minced or smooth pureed diet also received a choice of meals. Vegetarian options were available to the residents from the menu.

The catering staff had a good knowledge of those on special diets such as weight reducing, coeliac, 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 alternation to the normal 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. 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 their residents’ meeting. A number of examples of resident feedback were given to the inspector. For example, a recipe for a residents stew was on the menu. The inspector was told that any food service was discussed and feedback from residents informed menu planning at the good life group.

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. A dietician was visiting a resident on west wing on the day of the inspection and outlined her role to the inspector. 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 interdisciplinary team members and the relevant guidance.

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 also a speech and language service and occupational therapist available to assess residents. Access to speech and language, dietetics, and occupational therapy was good, with clear documentation of assessment and review.

Peripatetic staff were also involved with providing education and support to the multi-disciplinary team. Education records showed staff had received training in several areas in relation to food and nutrition including dysphagia, modified texture diets, and malnutrition screening.

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. Residents confirmed to the inspector that family occasions such as birthdays were celebrated at the centre with provision of cake to celebrate special occasions.

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:

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