<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Harvey Nursing Home Terenure</th>
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</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000047</td>
</tr>
<tr>
<td>Centre address:</td>
<td>122-124 Terenure Road West, Terenure Road, Dublin 6w.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 490 7764</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:bronagh@harveyhealthcare.ie">bronagh@harveyhealthcare.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<tr>
<td>Registered provider:</td>
<td>Willoway Nursing Home Limited</td>
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<tr>
<td>Provider Nominee:</td>
<td>Hilda Gallagher</td>
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<tr>
<td>Lead inspector:</td>
<td>Helen Lindsey</td>
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<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>47</td>
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<tr>
<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 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: 08 July 2014 07:45
To: 08 July 2014 13:45

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

The inspector found a good level of compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland. Nutritional assessments were seen to be comprehensive, and included guidance from allied professionals to ensure residents did not experience poor nutrition and hydration. End of life practice in the centre was developing to become more comprehensive at the assessment stage, and feedback from relatives was positive about the care provided at the centre.

Residents requiring end-of-life care received a caring service at this stage of life from staff who knew their needs. Individual’s needs were recorded in care plans, including their preferences and wishes in more recent admissions. Staff had received training in palliative care, and the relatives of previous residents provided mostly good comments.
The nutrition and hydration needs of residents were met. Residents were provided with food which was varied and nutritious and respected their preferences. There was a good standard of nutritional assessment and monitoring and residents had access to general practitioners (GP) and other allied professionals when required. Audits were carried out monthly to identify any residents who needed more support to maintain good nutrition and hydration levels. Residents all gave very positive feedback about the quality of the meals and the support the staff provided.

These matters are discussed further in the report.
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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Residents received a good standard of end-of-life care, which respected their individual needs.

There were written and operational policies and protocols in place for end-of-life care. It covered guiding principles, assessment of needs, care planning, and care of the dying resident. New care planning documentation had been introduced earlier in the year, with an improved section on end of life wishes.

The inspector read a number of care plans and found residents had basic end-of-life care plans in place, in the event that they became seriously unwell and were unable to articulate their wishes. The plans for people who had been resident for a while covered spirituality and dying in a basic way. The new plans used for any new admissions since March included more detail, for example recording residents wishes around their care at end of life and their preferred place of death. There was a section of the care plan that covered spirituality in more detail, including religious preference, factors that prohibit practice, and whether they would like sacrament of the sick. The person in charge confirmed that on admission they were starting the discussion about end of life care, and discussing wishes around treatment at an appropriate time. There were some ‘do not resuscitate’ orders recorded in some GP notes for individual residents, but the person in charge was implementing a new form that would involve the resident, GP and where appropriate, relatives in recording wishes in a more standardised way.

The general care plans covered residents physical, emotional and psychological needs in the initial assessment, 3 monthly reviews and the nursing care plans where there was a specific need identified.

The inspector saw evidence of residents receiving services from allied health professionals, such as dietician, speech and language therapy, and occupational therapy. The person in charge confirmed there was a dentist who visited the centre. There was also evidence of regular review from the general practitioner (GP); this also included review of medication.
Palliative care services were seen to have been in place for those who needed it in the past, and staff spoken with said the service was very supportive of residents in the centre. The records seen for residents who had passed away showed there had been a joined up service between the centre and the palliative care team.

At the time of the inspection there were no residents who were receiving end stage care. Residents were seen to be receiving day to day care from staff that knew their individual needs and engaged with them in a positive way. Staff spoken with were knowledgeable about how to support a resident at end of life, with a strong focus on respect.

Staff confirmed they had either completed training about palliative care, or were booked a session taking place on the 24th July which would complete the training for the full staff team. Staff were positive about the training, and it made them think of ‘end of life care’ as longer period of time. One person said it made them really focus on pain management and making the family feel at ease. At the time of the inspection there was sufficient staff to meet the needs of the residents.

All religious and cultural practice was facilitated. Residents confirmed they were able to attend religious services in the centre, including Mass and Rosary, and could access priests when they wanted to see them.

Relatives who completed the questionnaires before the inspection confirmed they were able to spend time with their relatives and were always made to feel welcome. They were generally positive about the support they and their relative received at end-of-life from the staff and the person in charge. One relative said “Mother was happy and very well looked after”. Documents were seen that recorded the agreement with relatives about the removal of the person following death.

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

Relatives confirmed they were able to stay through the night if they wished. Staff confirmed this could be with their relative, or in the relative’s room on one of the easy chairs. Arrangements were in place to return residents personal belongings at a time that suited the relatives. Items were handed over using the resident’s own suitcase, or a special bag purchased by the centre for this purpose.

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

**Findings:**
Residents received food and drink at times and in sufficient quantities to meet their needs, and in line with their personal preferences.

There was a policy on monitoring and documentation of nutritional intake that gave clear guidance to staff. The inspector observed that it was being implemented in practice. For example assessing resident's nutritional status on admission and then reviewing at least every three months or more often if needed. Nursing staff spoken with were very clear in their role of monitoring residents for any sign of reduced intake of food or drink, and were able to explain what action they would take, for example if the outcome of an assessment showed increased risk of malnutrition they would request a review from the speech and language therapist or dietician. Records seen by the inspector showed monitoring of intake/output was being used where residents were not taking a full diet.

The inspector reviewed a number of care plans and supporting documents, such as speech and language assessments. They were individual to the residents and included food preferences. Special diets for residents were recorded and matched the recommendations of the allied professionals, for example dietician. They also showed good evidence of monitoring residents, for example weight, body mass index and malnutrition screening. Dental services were available via a mobile dental service, or a dentist of the resident’s choice.

Some residents were seen to take nutritional supplements. These had been agreed with the general practitioner (GP) who had prescribed them, and then kept them under review. They were clearly recorded on the prescription records of residents.

Staff handovers at the beginning of the shift identified those who needed to be monitored, and each staff member was allocated to a resident if they needed assistance at meal times. This system worked well, and staff were seen to be taking time in supporting residents to drink and eat meals, going at the preferred pace of the resident.

Monthly audits were being carried out for all residents’ nutrition and hydration needs reviewing. The audits identified people at risk of malnutrition and ensured that referrals had been made to allied health professionals as required, including occupational therapy. The audits provided a lot of information for the management team to check the practice in the centre against the policy and the organisation’s quality assurance system.

The inspector observed the service of breakfast and the main lunch time meal to residents. Meals were seen to be properly prepared, cooked and served. Residents were seen to have good access to food and drink through the day including fresh drinking water. There were two choices offered for the main meal. Residents confirmed that if they wanted something other than was on the menu, it would be arranged for them,
and that they got sufficient quantities for food. They also confirmed they could have drinks at any time if they asked. Kitchen staff confirmed that care staff were able to access food for people in the evenings and through the night. This included sandwiches and ice-cream for example. Every resident spoken to during the inspection gave very positive feedback about the quality of the meals.

On the day of the inspection all residents had their breakfast in their room. Residents were able to choose the time they wanted their breakfast, and it was usually served between 7.15 and 9.30, although some residents were seen to be having it at a later time. Many people were sat up in bed, while others sat in a chair with a small table. Staffing levels reflected the needs of those who required assistance. Residents were eating a range of cereals and toast. When spoken with, residents confirmed they had a choice of what type of cereal and bread to have.

At lunch time most residents ate in the dining room over two settings at 12.00 and 12.30. A small number of residents had their meal in their rooms if they chose or were resting. Some residents ate in the other areas of the centre, especially if the preferred a quiet environment. Support was seen to be appropriate to residents needs with staff supporting people sensitively and offering encouragement where it was needed. Pleasant conversations were being held with residents about topics they were interested in.

Kitchen staff plated up meals for individuals and staff delivered the covered plates to the tables and rooms. The food was well presented, including modified diets and the meal was unhurried. Tables were laid out with cutlery, condiments and napkins. Trays for people in their rooms were also well presented.

The kitchen was seen to have adequate storage for fresh and stored food items. The chef had been employed in the centre for a long time, so had a very good knowledge of the resident’s likes and dislikes, and was seen to cater to them. There was also an up to date record of those residents on modified diets, which matched the care plans that had been reviewed. Meals were provided for a range of dietary needs including residents who were diabetic. Home baking was seen to offer choices for those on alternative diets.

The menu ran over 4 weeks, and was changed seasonally. The menu had previously been reviewed by a dietician, to confirm it was nutritious, who had made recommendations. The amended menu was with them at the time of the inspection for further comment. A meeting was held with residents to gain feedback about the meals served. The last record showed feedback was generally positive, but that residents would like more ‘sausages and rashers’. This change was seen to have been applied to the menu.

There was also an advocacy meeting held in the centre at regular intervals that would also seek resident’s views on meals and mealtimes. The last record showed positive feedback.

Staff had received training on nutrition and hydration through a nutrition company. The training included guidance on nutrition in older people. Staff, including kitchen staff,
confirmed they had learned new information on the courses and were putting it into practice, for example the importance of variety.

There was no access for residents or relatives to make their own drinks, but those spoken to said they would be provided if they asked.

**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:**

Helen Lindsey
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority