<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Dalkey Lodge Nursing Home</th>
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</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000771</td>
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<tr>
<td>Centre address:</td>
<td>Ardbrugh Road, Dalkey, Co. Dublin.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 285 1486</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:dalkeylodge@ardmorecare.ie">dalkeylodge@ardmorecare.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>Dalkey Lodge Nursing Home Ltd</td>
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<tr>
<td>Provider Nominee:</td>
<td>John Martin</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>
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<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>28</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.
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: 20 August 2014 08:00
To: 20 August 2014 14:45

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 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. Nine were sent out, and six were returned. The inspector met residents, staff and observed practice on inspection. Documents were also reviewed such as policies 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 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland. The policies were detailed, and guided the practice of the staff to meet the needs of the residents.

End of life practice was well established, and included gathering information from residents and their relatives, where appropriate, about their future wishes, including areas such as treatment, and preferences around religious and spiritual support.

Residents were supported to maintain good food and drink intake that was provided in a way that met their assessed needs. Choice was offered about the food and drink they had, and where they wanted to have it. Feedback from residents was positive about the quality of meals they received. 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):**
No actions were required from the previous inspection.

**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. They covered guiding principles, assessment of needs, care planning, and care of the dying resident. The care planning section focused on the plan being individual, and providing information on the resident’s needs, wishes and preferences. The policy also provided information for a range of different religious practice in relation to end of life care.

The inspector read a number of care plans and found all residents had end-of-life care plans in place, in the event that they became seriously unwell and were unable to articulate their wishes. The plans reflected the conversations held with the resident, and their families where appropriate, and the person in charge. Some people had thought about their wishes in relation to care and treatment in detail, and others were sensitively supported to start to think about this. The person in charge confirmed that she would be training the clinical nurse managers to undertake this role, as well as herself, as they would also be assessing prospective residents needs.

There were some ‘do not attempt resuscitation’ orders in place for residents who had made that request. This was recorded on a brightly coloured page in the resident’s notes so the information could be easily accessed. It was signed by the GP, and resident or next of kin and was regularly reviewed.

The end of life care plans in place for all residents covered the anticipated loss of psychological well being, and how to support the resident and their families at this time. Their needs were identified in the pre-admission assessment, comprehensive assessment and the care plans. There were 3 monthly reviews in place and nursing care plans were in place where a specific need was identified. The information recorded covered their physical needs, preferences around treatment and admission to hospital, wishes around place of death, wishes around spiritual and cultural preferences and after their death instructions, for example where they wanted to be buried.
The inspector saw evidence of residents receiving services from allied health professionals, such as dietician, speech and language therapy, and occupational therapy in the clinical notes and in the assessments that had been completed. There was evidence of regular review from the general practitioner (GP); this also included review of medication. The person in charge reported that palliative care services were available and had been used for those who needed it in the past.

During the inspection residents were seen to be receiving day to day care from staff that knew their individual needs and were supporting them in their daytime activities. Staff spoken with were knowledgeable about how to support a resident at end of life, with a strong focus on respect.

Staff confirmed, and records showed they had completed training about end of life care. The person in charge had a lot of knowledge about this topic due to previous work experience, but also arranged formal training from external providers.

At the time of the inspection there were sufficient staff to meet the needs of the residents.

All religious and cultural practice was facilitated. Resident’s confirmed they were able to attend religious services in the centre. Resident’s religion and preference for different practices, such as the sacrament of the sick, were clearly recorded.

At the time of the inspection there were no residents who were receiving end stage care. However feedback received from relatives who had completed the questionnaire were positive. For example relatives said “mother was given excellent care” and “can’t think of more that could have been done”. They confirmed they were able to spend time with their relatives and were always made to feel welcome, and that they were able to stay through the night if they wished. Staff confirmed this could be with their relative, or in the sun room.

All of the bedrooms in the centre were single, so resident’s privacy and dignity was able to be maintained in a calm environment as they reached the end stages of life.

After a resident had passed away, arrangements were in place to return their personal belongings at a time that suited the relatives. Items were handed over using the resident’s own suitcase, or a suitable bag. A sympathy card was sent from the home to relatives, and a bereavement pack was available in different denominations. It included information on dealing with bereavement, a list of agencies that could be contacted, list of funeral homes, and list of local churches.

Signage was available in the home to indicate that someone had passed away. This informed both staff and residents of the news. Staff would also tell residents individually, and provide support if they needed it.

The records seen for residents who had recently passed away showed there had been clear plans in place to ensure they received the care and support they needed.
Documents were seen that confirmed the steps identified in the centre's policy were completed, which supported the person in charge to monitor practice within the centre and ensure it was of a good standard. Following the passing of a resident, the person in charge undertook a ‘reflective practice’ session to support staff to think about the events and identify what had gone well, and any areas of care that could be improved.

**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 residents' needs as part of the pre-admission assessment, comprehensive assessment and then in the 3 monthly care reviews.

The inspector reviewed a number of care plans and supporting documents, such as speech and language assessments. Care plans clearly recorded residents' preferences around the type of food they liked, the time they liked meals, and the size of meal they preferred. The care plan also set out their needs around eating, for example whether they were independent or needed support. All residents were observed for 7 days on their admission to the service to assess their intake and so a baseline could be identified. This process made sure any issues that may need further investigation were identified.

There were a range of processes implemented in the centre to ensure good nutrition and hydration which included having care plans in place, taking peoples weights weekly or monthly depending on their needs, 3 day monitoring of intake if concerns noted, and referrals for professional input where needed.

The referrals were made to allied services when there were concerns, for example they had a low body mass index score. Records showed there was regular review of residents from general practitioners (GP’s). Dietician assessments were in place for those who needed them, as were speech and language assessments. There were also dental and
chiropody services who visited the centre regularly. Occupational therapy services were available but had not been needed, and a physiotherapist had assessed a number of residents needs, and recoded their findings in the care plans.

A range of dietary needs were clearly recorded for residents including whether they had their meals in a modified consistency, had the food fortified to make it higher in calories and protein, or whether they had special diets, for example diabetic. This information matched the assessments completed by the dietician and speech and language therapist.

Some residents were seen to take nutritional supplements. These were recommended by the dietician, agreed with the general practitioner (GP) who had prescribed them, and then kept them under review to see how effective they were.

Staff spoken with were clear about their role of supporting residents to eat and drink and also monitoring for any changes of intake. This information was recorded on a form and brought to the attention of the nursing staff. Records seen by the inspector showed monitoring of intake/output was being used where residents were not taking a full diet. During the inspection staff were seen to be taking time in supporting residents to drink and eat meals, going at the preferred pace of the resident.

Staff were advised of any residents changing needs, or specific action needed during the staff handover at the beginning of their shift.

Staff had received training on nutrition and hydration through a nutrition company. Most staff had also completed a safe food handling course. Kitchen staff had completed the required training around safe preparation and handling of food, and they attended the other courses on nutrition run at the centre. The chef was clear on how to follow the guidance from speech and language therapists, and kept information in the kitchen for quick reference.

The inspector observed the service of breakfast and the main lunch time meal. Residents were seen to receive meals that had been properly prepared, cooked and served in an appealing way. There was choice for each meal, for example breakfast options included cereal, toast or hot options such as porridge or a cooked breakfast (sausage, egg, rashers) and always two choices offered for the main meal.

Residents told the inspector that the food was of a very good quality, and that they got enough to suit their needs. They also said staff listened to what they wanted and got it for them, and confirmed they could have drinks or snacks at any time if they asked day or night, but didn’t need to as they got enough at the set meal times. Kitchen staff confirmed that care staff were able to access food for people in the evenings and through the night. They were seen to have good access to food and drink through the day including fresh drinking water.

On the day of the inspection most residents had their breakfast in their room. Residents were able to choose the time they wanted their breakfast, and it was usually served between 7.30 and 10.00 but could be provided earlier or later if that was the preference of the resident. Many people were sat up in bed, while others sat in a chair with a small
Staffing levels reflected the needs of those who required assistance.

At lunch time most residents ate in the dining room, or their rooms. Support was seen to be appropriate to residents needs with staff offering assistance to people sensitively and encouragement where it was needed. Residents and staff were observed to be chatting about a range of topics over the course of the meal which was unhurried.

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. Tables were laid out with cutlery, condiments, napkins and flowers. Trays for people in their rooms were also well presented.

The kitchen was seen to have adequate storage for fresh, frozen and dry food items. The chef and kitchen staff had a very good knowledge of the resident’s likes and dislikes, and were seen to cater to them. There were records in the kitchen for quick access of the information. 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 been reviewed by a dietician, to confirm it was nutritious. The chef was in the process of developing the winter menu, and was speaking to residents individually to confirm they liked the options available. For example residents had asked for more, homemade brown bread, stew and apple pie, which had been included. The chef also rechecked residents preferences to ensure the list they held in the kitchen was up to date.

There was a residents meeting monthly where feedback was sought on the food, and the record showed positive comments about activities such as a garden BBQ party.

The inspector reviewed the log of complaints at the service, and noted that none related to the quality of food. One referenced the quantity provided but this had been followed up and found not to be an issue.

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

Recent environmental health reports were seen, and a small number of recommendations had been made. Evidence was seen that the improvements had been completed, or were in the process of being addressed. For example the storage containers for the vegetables had been replaced.

Audits on food and nutrition had been carried out by the person in charge. 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 dietician had also carried out 6 monthly audits which included the menu. Changes had been made to implement the outcomes, for example reducing the amount of saturated fat in the food served.
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