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:	Abbeygale House
Centre ID:	OSV-0000743
Centre address:	Farnogue, Old Hospital Road, Wexford.
Telephone number:	053 912 4002
Email address:	barbara.murphy@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Barbara Murphy
Lead inspector:	Kieran Murphy
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	21
Number of vacancies on the date of inspection:	1

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, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 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:
30 September 2014 11:00	30 September 2014 17:00

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

Outcome	Our Judgment
Outcome 04: Suitable Person in Charge	Non Compliant - Major
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Minor
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 11: Health and Social Care Needs	Non Compliant - Minor
Outcome 14: End of Life Care	Compliant
Outcome 15: Food and Nutrition	Compliant

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 received evidence-based guidance and undertook a self-assessment in relation to both outcomes.

Abbeygale House was part of a group of three centres under the overall management of the Health Services Executive. It was a purpose built unit which was bright spacious and well maintained. On the day of inspection there were 18 single en suite bedrooms occupied and one three-bedded en suite room had two residents. There were a number of sitting rooms available throughout and a secure outdoor landscaped garden area.

The inspector met residents and staff and observed practice. Documents were also reviewed such as policies, procedures, training records, care plans, medication management charts, menus and minutes of residents' meetings.

A number of questionnaires, completed by relatives of recently deceased residents, were received prior to and following the inspection. All responses reflected satisfaction with the care received with several specifically mentioning the kindness

of staff to residents and families. Other questionnaires outlined that residents at end of life were treated with respect and dignity by staff.

In relation to end of life care the centre had assessed itself as having a minor non-compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and National Quality Standards for Residential Care Settings for Older People in Ireland.

In relation to food and nutrition the centre had assessed itself as compliant with the regulations during the national self assessment on food and nutrition undertaken by the Authority. The inspector found evidence to support this assessment.

While the thematic inspection focused on two outcomes as described above, there was a requirement for the inspector to review other outcomes in so far as they related to end of life care and food and nutrition. Some minor non-compliances were identified, particularly in relation to prescribing of oral nutritional supplements by dieticians. Other issues included fire safety and these are discussed in more detail in the body of the report.

The Action Plan at the end of this report identifies where improvements were needed.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge was in charge of more than one designated centre. However, an outline of the arrangements to ensure the effective governance, operational management and administration of the designated centres were not available on the day of inspection.

Judgment:
Non Compliant - Major

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

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

Findings:
There was an end of life care policy in draft format which outlined a framework approach to end of life care. The policy included pain management, spiritual needs and care, verification of death recording, notification of a resident death to the Coroner and

support for the residents and family. The core of the policy around issues like early identification of residents nearing end of life had not been implemented in practice. However, a training programme was to be introduced whereby two nurses would be specifically educated around end of life and the framework approach to care. These nurses would be certified to provide this training to the rest of the staff. Once this initial training was completed, the end of life care policy was to be approved by the end of life care committee.

The inspector found that the mechanisms in place for managing residents' healthcare records required improvement. There were two active healthcare files, the first relating to nursing care planning and the second relating to medical and allied healthcare records. While the nursing files were maintained out of sight at each nurses station, some medical care records were stored in a filing cabinet on the corridor, the lock of which was broken, and so not guaranteeing confidentiality of residents' records. The lock to the cabinet was fixed during the inspection.

Other daily records including observation sheets and administration records for nutritional supplements were maintained in the residents' bedroom in a closed locker. However the inspector observed a number of these records on the corridor outside the bedroom where they could be accessed easily by other residents or visitors. These were removed and stored appropriately during the inspection.

Current swallow care plans were available on the wardrobe in residents' bedrooms. Guidance received by the centre from the Irish Association of Speech and Language Therapists in May 2012 outlined that over the bed signage was recommended for a number of reasons including the danger of overfeeding residents or feeding incorrectly.

Judgment:
Non Compliant - Minor

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

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

Findings:
In relation to fire safety, the unit was divided into separate fire resisting compartments. In the event of a fire the plan was for residents to be moved from the compartment involved in the fire to the adjacent compartment and if necessary moved again. These compartments were accessed via fire doors. However, on the day of inspection two of these compartment fire doors were noted to be wedged open and so could not be used to prevent the spread of fire. Additional doors, which were marked as fire doors in a

sitting room and the nurse manager's office, were also observed to be wedged open.

The inspector noted a number of issues with the premises that required risk assessment:
• The lock of the door from the corridor to the main kitchen was switched to "off" and there was a hazard that residents could enter this area and have unrestricted access to the kitchen which contained a 24 hour hot water boiler
• the door to the staff kitchen area was held open by a chair. While access to this general area was via a secure key pad there was a hazard that residents could enter this area and have unrestricted access to the staff kitchen which contained a 24 hour hot water boiler
• there was a kettle in the main dining area, which the provider outlined was there for visitors to have a cup of tea with residents. The hazard of scalding from unrestricted access to this kettle had not been risk assessed.

Judgment:
Non Compliant - Major

Outcome 11: Health and Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's 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:
Person-centred care and support

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

Findings:
There was a nutrition committee with membership including nursing staff, catering staff and dieticians from Abbeygale and two other centres. This committee oversaw all aspects of nutritional care for residents, including the implementation of centre specific guidelines on the use of oral nutrition supplements (supplements). These guidelines, which were introduced in 2012, outlined arrangements for a dietician prescribing oral nutritional supplements. Dietician prescribing had been introduced on a trial basis under the supervision of the nutrition committee. As will be discussed in more detail later in this report each resident was being screened appropriately for nutritional requirements using the Malnutrition Universal Screening Tool (MUST). Prior to the introduction of supplements alternative options for oral nutrition support were also considered including energy dense foods at each meal and fortification of meals with milk or cream as appropriate. Clear goals and a nutrition care plan were set with residents by the dietician prior to prescribing and starting supplements. However, there wasn't any evidence that the general practitioners (GP) had agreed to dietetic prescribing. In addition there wasn't any guidance or procedure in place to outline the conditions when

GPs can prescribe oral nutritional supplements, for example following a review of the resident at the weekend.

For each resident requiring an oral nutritional supplement there was a nutritional supplement prescription sheet from the dietician. This prescription sheet outlined the supplement type, the dosage and time of administration. There was a supplement recording form to document the time each resident received the supplement. Given the dependency levels of residents the majority of residents requiring supplements were receiving them in their bedrooms. Both the dietetic prescription and administration recording sheet were kept in the resident's bedroom. Nursing staff outlined that the recording of the administration of the supplement was being undertaken at the point of care at the time it was given.

From a review of a sample of prescription sheets the inspector found inconsistencies in practice during the trial period of this dietetic prescribing. Some residents had a dual prescription of supplements both by the dietician and the doctor while other residents had the supplements prescribed by the dietician only. Some of the supplements on the main prescription sheet had been discontinued but the date of discontinuation had not been recorded.

The minutes of the nutrition committee meeting from September 2014 outlined a review of the dietician prescription process needed to be undertaken as some members of the committee had concerns that if the supplements were not recorded on the main medication prescription sheet supplements may not be given and if given not recorded.

Judgment:
Non Compliant - Minor

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 an end of life care committee which had overall oversight of residents care in Abbeygale and two other centres. The minutes of the most recent committee meeting in September 2014 were available and indicated that the end of life policy was currently under review. The policy is covered in more detail in outcome 4. An intercultural guide was available on each ward which contained information on various faiths and cultures.

Care plans reviewed by the inspector identified spiritual needs of residents including visits from pastoral care. As any change or health deterioration occurred the end of life

care plans were updated and recorded as "variances" (i.e. changes to the care plan). The centre had introduced an advanced care planning process. While not every resident had such a plan in place it included issues like:

- what was important to the resident
- values
- spiritual/cultural needs
- what their wishes for care was if their health deteriorated
- did they wish to transfer to an acute hospital or return home at end of life.

In the healthcare records reviewed there was evidence of appropriate assessment and review of residents at end of life by the GP. Staff indicated that the community palliative care team were available if required.

There was a bright and spacious oratory with religious services being held regularly. Following a resident's death there was an end of life care box available which included sheets, candles and oils. A guard of honour was formed as a mark of respect while the resident's remains were removed from the centre. Tastefully decorated hold-all bags were available for the return of a resident's property to family. The inspector found this initiative to be respectful of residents and their possessions. Following the death of a resident a letter of condolence was sent to the family with a memorial service being held one month later.

There were clear guidelines following a resident's death available for staff for contacting the family, the medical officer, the coroner (if required), pharmacy and the undertaker. Records seen by the inspector showed that all of these guidelines were being implemented appropriately by staff.

Single en-suite rooms were available for residents at end of life. The advanced care planning documentation recorded residents' wishes regarding if they wanted to remain in the centre, an acute hospital or go home. Documentation submitted to the Authority indicated that most residents chose to remain in the centre.

There was unrestricted access for families of residents at end of life, with showering and dining facilities made available. Comfort baskets, which included toiletries and towels, were made available to families who stayed with residents. There were a number of sitting rooms available which families were encouraged to use.

The clinical nurse manager indicated that, in conjunction with the introduction of the new end of life care policy, training would be given to all staff. Two staff were undergoing a specific education course which incorporated awareness of what end of life care is, how to manage a resident's pain, communication and how to reduce a resident's need for acute hospital care. These trainers were to disseminate the information to the rest of the staff. At present there was a formal review with staff regarding the care provided to a recently deceased resident. This provided staff with the opportunity of sharing memories of the resident but also informing practice to see if the care provided was of the expected standard.

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):

Findings:
There was an up to date policy on nutritional status and hydration care. This policy was supported by a range of specific policies on nutrition and hydration including guidelines for:
• Use of malnutrition universal screening tool (MUST) assessment
• use of oral nutrition supplements
• enteral (directly to the stomach) feeding guidelines
• therapeutic diets.

On admission each resident had an initial malnutrition universal screening tool (MUST) assessment. There was also recording of weight and body mass index. In the sample of healthcare records reviewed residents had a MUST score recorded monthly. The inspector saw that residents were referred for review by a dietician based on these MUST scores. The clinical nurse manager had undertaken an audit of the use of the MUST assessment tool. This audit of 10 healthcare files, completed in February 2014, found all MUST assessments had been dated and all residents were appropriately referred for dietetic review. The action from the audit included staff receiving further education from the dietician.

Nutritional care plans had been completed following dietetic review on 18 of the 22 residents. These care plans outlined:
• The aim of the nutritional plan: to prevent further weight loss for example
• type of diet: for example pureed, soft, moist etc
• fortification: does the person require extra milk, cream or an extra dessert
• drinks: does the person require drinks to be thickened
• supplements: if required or not
• assistance: does the person require assistance with eating

Nursing care plans were available for all residents around the activity of eating and drinking. Any change to the care plan was recorded, like when food needed to be liquidised or if a nutritional supplement was no longer required. Each dietetic review was also recorded in the nursing care plan.

If the resident had dysphasia (swallowing difficulties) there was evidence of appropriate referral being made for speech and language assessment. As outlined earlier in Outcome 4 relating to documentation the recommendations from the speech and language

therapist were available in swallow care plans in the residents' bedroom. A copy was also available in the healthcare file. Recommendations from the dietician and/or speech and language therapist were communicated to the catering staff. Up to date copies of each resident's dietary requirements were maintained in a communication folder in the main dining room.

The inspector met with the catering assistant who had completed training on the management of food hygiene. Meals were prepared in the main kitchen in another centre and transported via hot trolleys in a van from the main kitchen to the kitchenette on the unit. A menu plan was available on a four weekly cycle. A food satisfaction survey was completed in February 2014 which 40% of residents completed. The survey covered issues like meal presentation, taste, variety service and choice. Overall residents were satisfied with the meals. The residents' council meeting had food as an agenda item and minutes of the meeting reflected that residents enjoyed the menu on offer.

The inspector observed mealtimes including mid morning refreshments, lunch and tea. Due to residents dependency levels and the need for assistance with eating, a number of residents were assisted with their meals at their bedside. In addition there were two dining rooms, one for residents who required assistance with eating and the second dining area for residents who could eat independently. The tables were set in an attractive manner. The inspector noted that lunch, in sufficient portions, was plated and presented in an appetising manner. Staff were observed assisting residents in a sensitive manner. There was access to fluids and snacks throughout the day and tea trolleys were seen in circulation during the morning.

The most recent Environmental Health Officer report was available. A record of staff training submitted to the Authority indicated that 15 staff had recently received training on dysphagia.

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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Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Abbeygale House
Centre ID:	OSV-0000743
Date of inspection:	30/09/2014
Date of response:	07/11/2014

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure 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.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 04: Suitable Person in Charge

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An outline of arrangements in place for effective governance were not available on the day of inspection.

1. Action Required:
Under Regulation 14(4) you are required to: If the person in charge is in charge of more than one designated centre provide evidence to the chief inspector that the

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

person in charge is engaged in the effective governance, operational management and administration of the designated centres concerned.

Please state the actions you have taken or are planning to take:
There will a ward round done on a five day basis by either one of the Assistant Directors of Nursing or the Director of Nursing over the seven week days. In addition there is a daily report faxed to the ADON in St Johns Community Hospital, Enniscorthy. All policies and procedures and governance for the 21 beds in Farnogue are part of the overall long stay elderly services one of three units in Wexford and they are managed as one with one Director of Nursing and one Hospital Manager.

Proposed Timescale: 10/11/2014

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The end of life care policy was in draft format.

2. Action Required:
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

Please state the actions you have taken or are planning to take:
Training from Gold Standards framework commenced on 23rd October 2014
Being rolled out over a six month period
On completion of training the policy will be implemented.

Proposed Timescale: 31/05/2015

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Risk assessments were not available for:
• The lock of the door from the corridor to the main kitchen was switched to "off" and there was a hazard that residents could enter this area and have unrestricted access to the kitchen which contained a 24 hour hot water boiler
• the door to the staff kitchen area was held open by a chair. While access to this general area was via a secure key pad there was a hazard that residents could enter this area and have unrestricted access to the staff kitchen which contained a 24 hour

hot water boiler
• there was a kettle in the main dining area, which the provider outlined was there for visitors to have a cup of tea with residents. The hazard of scalding from unrestricted access to this kettle had not been risk assessed.

3. Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
Lock on the door from the corridor is now switched to "on"
Door of staff kitchen will be kept in the closed position
Kettle is now locked away and all residents/next of kin are advised of the process to avail of boiled water for beverages which is to contact the staff on duty and request the kettle if they wish to make a hot beverage.

Proposed Timescale: 10/11/2014

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Two compartment fire doors were noted to be wedged open and so could not be used to prevent the spread of fire.

4. Action Required:
Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
The Technical Services Department have audited the building and consulted with the CNM2. Doors will no longer be wedged open and instead will be linked into a magnitised fire system which will hold the doors in the open position but if activated by fire will automatically close.

Proposed Timescale: 31/03/2015

Outcome 11: Health and Social Care Needs

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There wasn't any evidence that the general practitioners (GP) had agreed to this

dietetic prescribing. In addition there wasn't any guidance or procedure in plan to outline the conditions when GPs can prescribe these oral nutritional supplements, for example if it is a respite resident or following a review of the resident at the weekend.

5. Action Required:
Under Regulation 06(2)(b) you are required to: Make available to a resident medical treatment recommended by a medical practitioner, where the resident agrees to the recommended treatment.

Please state the actions you have taken or are planning to take:
Procal Shots are being prescribed by the Medical Officer at Abbeygale Unit. The reason why Procal Shots are being prescribed in such a manner is because the amount can vary per person for example some residents may be prescribed for 20mls others for 40mls
The Dietetic products such as puddings and yogurt like substances are available in 250ml yogurt like cartons and it is acceptable for the resident in receipt of same to choose the amount they wish to ingest at any one time
The amount of these products are prescribed and recorded on the Dietetics recording sheet and each member of the direct care team enter the amount that the resident has ingested at anyone time

Going forward a meeting will take place with the dietician, Medical Officer, Director of Nursing and Clinical Nurse Manager 2 at Abbeygale I await a date for same. From Monday 17/11/2014 the Medical Officer will be requested to write a report in the residents clinical notes each time he prescribes a dietetic recommended product. As a part of the above Multidisciplinary Meeting Weekend prescribing and Respite prescribing of Dietetic products will be discussed and an agreed outcome will be obtained following all rules policies and guidelines .

Proposed Timescale: 17/11/2014