

**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



Centre name:	Lusk Community Unit
Centre ID:	ORG-0000505
Centre address:	Station Road, Lusk, Co. Dublin.
Telephone number:	01 807 1240
Email address:	mary.carney2@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Sheila Marshall
Person in charge:	Geraldine McNally
Lead inspector:	Leone Ewings
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	50
Number of vacancies on the date of inspection:	0

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:	To:
10 June 2014 11:00	10 June 2014 18:30

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 thematic inspection which focused on two specific outcomes, End of Life Care and Food and Nutrition. In preparation for this thematic inspection the person in charge attended an information seminar. Providers and person in charge had received evidence-based guidance and undertook a self-assessment in relation to both outcomes. The person in charge had judged that the centre had a minor non-compliance 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 inspection.

End-of-life care practices and outcomes for residents and relatives were found to be of a good standard. End-of-life policy reflected some practices. Feedback from relatives of residents who had died at the centre was very positive overall. Staff were highly praised for the level of good communication and the kind, sensitive and friendly manner in which they treated each resident. However, some improvements were required in relation to the policy document which guides staff relating to end of life care and timeframes around completion of end of life assessment documentation and details of supports in place for residents and staff following a bereavement were not clearly outlined in this document although were in place. The inspector also found that more specific written information on services and supports available to relatives were not always offered to relatives following family meetings if appropriate and following the death of a loved one to further assist and guide them.

Food and Nutrition outcomes and practices were of a very good standard. Residents spoken with confirmed this and mealtimes were observed to be a very social

occasion. All residents' needs were met with regard to maintaining independence and appropriate assistance from staff when required with eating and drinking. However, the menus available had not been reviewed by the dietetic services with regard to nutritional content. Access to occupational therapy referrals for residents requiring assessment or review was not clearly identified on the self assessment or at the time of the inspection. However, the inspector did not identify any outstanding needs not currently being met in this area, but recommends a formal system of facilitating referral when required if put in place by the provider.

From evidence gathered on inspection the inspector formed the view that the centre was in minor non-compliance in relation to end of life and substantially compliant with regards to food and nutrition with recommendations made within the body of the report.

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 was to a high standard. The inspector saw that residents received end of life care which met their physical, emotional, social and spiritual needs and respected their dignity and autonomy. Records and documentation such as assessments, care plans, end of life discussions and transfer details of the deceased remains were completed with individual guidance. Written information on services and supports available to relatives was available to relatives after a death at the centre. However, written information following family meetings was not offered and the inspector recommended that this was considered and made available as appropriate and documented when offered. Improvements were required relating to documentation and return of residents property.

There was an end-of-life policy in place which reflected the care relatives said was provided to their dying relative in the centre. The policy was centre specific and was identified by the person in charge as requiring review when the self assessment was completed. The person in charge informed the inspector that this review had not yet taken place further to the self assessment. The policy was last reviewed and dated as 10 March 2013. Staff spoken with had an understanding of the policy and implemented care accordingly which upheld the dignity and respected the autonomy of residents.

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 14 questionnaires and at the time of the inspection 7 had been returned.

Some residents openly discussed deceased residents and the contribution to daily life they had made with their sense of humour and personalities. Residents confirmed attendance at funeral arrangements and services for past resident of the centre and found this a source of comfort. The inspector was satisfied that the deceased spiritual needs were met to date and relatives confirmed this in questionnaires returned. Questionnaires highlighted good communication and care provision by staff as a positive aspect of their experiences.

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 considered until very much later in the process. 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 antibiotics intravenously and in addition sub cutaneous fluids which could be prescribed and administered. A high standard of consistent medical cover was evident from the medical records reviewed as part of this inspection.

The inspector confirmed with residents that they wished to stay at the centre and considered the centre their home. The inspector noted that 11 out of the 14 residents who had died in the past two years had died in the centre. A number of residents occupied shared bedrooms and recent improvements at the premises to provide additional private accommodation, had taken place to provide more ready access to a single room (if available) for end of life care. A respondent to the relatives' questionnaire had noted that transfer to a private room had been arranged, the respondent felt they had waited for this to be implemented. Another respondent commented that it was a source of comfort for their relative to remain in the same shared room as she had lived there for a number of years and it was familiar to them. Other relatives confirmed that a single room had been made available when required.

There was a visitor's 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 no actual sleeping arrangements in place for relatives, but relatives were welcomed to stay in the residents own room. 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 and spend time. 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 good 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 had access to the community based palliative care team, and training had been facilitated by the team for nursing and care staff. The inspector was informed that referral and review from the team was provided whenever necessary, however, in practice the skills were available at the centre with regard to palliative care and use of equipment such as syringe drivers and pain management. In house expertise was available and three staff identified to the inspector had completed post graduate qualifications in palliative care. Training has taken place with regard to individualised end of life care.

Nursing documentation was reviewed by the inspector and confirmed that nurses recorded residents' death and dying wishes/ preferences at the time of their initial assessment or during their three monthly assessment review. A yearly family meeting also took place (or more frequently as required) and this also prompted changes in the end of life care plans in place. Open discussions were recorded as taking place with regard to residents wishes relating to end of life care. In practice a review of residents transferred to hospital by the provider indicated that 29 residents had been transferred for acute care. The main reasons for transfer were related to treatments required for infections, diagnostic procedure, post-fall, and other medical interventions required of an immediate medical nature. The scope of practice of many nursing staff working at the centre included training completed on administration of subcutaneous fluids, and syringe driver for the delivery of subcutaneous medication. Pharmacy arrangements were in place to access out of hours if necessary.

Residents' religious needs were facilitated by the local priest in the community. The Sacrament of the sick was also provided and the priest sought at the residents' or relatives request. The centre is located in Lusk village and may access community services in the locality. Residents confirmed that a weekly mass service was held in the day room of the centre and a further service was held on Tuesdays by a visiting priest.

Relatives stated that there were sufficient staff on duty at the time of their relatives death. One relative appreciated being notified in a timely way that she needed to be present as her relative's condition was deteriorating and she had been prepared for this following discussions and communication from staff.

The end of life policy included details about caring for the remains of a deceased resident and the return of personal possessions to loved ones, and this was well documented. A specially arranged property bag was available for using for return of personal possessions. Information was available to relatives on the death of a loved one. However, the records of return of property to relatives was not formally recorded in the residents record, this gap was discussed with the person in charge who undertook to

rectify this. The inspector noted that the information available was not centre specific and this area could be developed further.

Education records showed staff had received training in relation to the provision of end of life care, and clinical training on symptom management and the use of the syringe driver when required. The documentation reflected a commitment to providing individualised end of life wishes for each resident.

Judgement:

Non Compliant - Minor

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 lunch and tea time. Snacks and refreshments were offered throughout the day at regular intervals and available for residents who needed additional nutritious snacks and found it difficult to sit down for mealtimes.

The policy on food and nutrition had been kept under review, most recently on 15 August 2013. It was robust and provided clear guidance to staff on how to care for residents' nutritional and hydration needs. The inspector saw that most 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 its 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.

There was also a policy on guidelines for care of residents with Percutaneous Endoscopic Gastrostomy (PEG) last reviewed on 31 January 2013. There were no residents receiving PEG feed on this inspection. A number of residents had been prescribed supplementary food and drinks. The inspector noted the administration of the prescribed drinks had not been signed for by nursing staff, or note made if a resident refused in line with policy and requested that this be reviewed by the person in charge to address this with 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 each resident stated they were individually offered a drink between each main meal and between supper and bedtime. Residents spoken with confirmed that staff provided them with a drink if and when they requested. For example, soup was offered together with tea, coffee and biscuits mid-morning. The appropriate equipment to meet the resident's needs such as modified cutlery and beakers with lids was found to be available for use. However, access to occupational therapy was identified in the self assessment as a deficit and referral for assessment and review not clearly identified for residents who required this, at the time of the inspection there were no residents with this outstanding requirement or need for referral.

The inspector observed lunch at 12.30hrs and tea at 16.30hrs being served to the residents. Residents confirmed they could choose where they wanted to eat. Residents had access to a communal dining room, which was proximal to the kitchen. Catering staff, prepared meals from the four week rolling menu and the chef served up to each resident present in the dining room, and smaller numbers eating in their meals in their own rooms. There was a choice of meat for lunch with a choice of potatoes and vegetables. Soup course was available earlier mid-morning and could also be taken with meals. Catering staff knew the residents likes/dislikes and needs. For example, some residents needed gentle verbal reminders to try their meals and re-direction. Residents spoken with told the inspector that they enjoyed the food service. The food service was visible to residents and the aroma of the foods added the lunch time food service. Residents could view the food prior to making a choice. 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 and in their own rooms as required.

The food choices available to residents were displayed on a menu on each table 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 being served. Residents who required a minced or smooth pureed diet also received a choice of meals,. Vegetarian options were available to the residents, there were no residents who required this option, but further to discussion with the chef a number of respite residents had been catered for the previous week.

The catering staff had a good knowledge of those on special diets such as weight reducing, celiac, 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 reviewed and feedback from residents informed menu planning. However, it was noted that further to discussion with the catering manager a review of the menus had not taken place from a dietetic perspective and it was recommended that prior to implementing the new planned menus that this took place. The person in charge undertook to follow up on this with the provider to obtain dietetic services for this review to take place.

The tea time service was of a similar service provision to the lunch time. Choices included chicken salad, eggs and every day a special was offered at tea time. Further to a review of the four week menu the inspector found that a hot food choice was always available to residents at tea time, with a further supper choice of sandwiches, cake and a hot drink at 20.30hrs, served by care assistants.

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. 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 inter disciplinary team members and the General Practitioner's (GP) instructions. The inspector noted that actual dates that weights were taken were not noted on the residents' monthly weight charts.

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 a speech and language therapist available to assess residents. Access to speech and language dietetics and dental assessments was good, with clear documentation of assessment and regular reviews. The dietetic service was in place once a month on a contract basis and this was currently meeting residents' needs.

The catering manager confirmed that updates on residents' assessments were updated for new admissions and daily when required using a paper system. Peripatetic staff were also involved with providing education and support to both care and catering staff. Education records showed staff had received training in several areas in relation to food

and nutrition including dysphagia, modified texture diets, malnutrition screening and referral criteria.

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. Cold drinks and snacks which were available at all times to residents. Residents confirmed to the inspector that family occasions such as birthdays were celebrated at the centre with provision of cake and fine dining in the small dining/visitors room and resident could invite guests if desired. Pictorial menus were not evident at the time of this inspection, but provision of choice was confirmed by observation of staff interaction and communication during the meal services.

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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Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Lusk Community Unit
Centre ID:	ORG-0000505
Date of inspection:	10/06/2014
Date of response:	08/07/2014

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 14: End of Life Care

Theme:

Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The end of life policy was not fully reflective of practices at the centre and required review relating to assessment timeframes, staff supports in place, provision of written information and documentation of return of personal property and effects.

Action Required:

Under Regulation 14 (1) you are required to: Put in place written operational policies and protocols for end of life care.

Please state the actions you have taken or are planning to take:

The End of Life Policy was reviewed and updated to reflect all aspects of care highlighted in the Inspection. All family meetings are held within one month of admission to establish the End of Life wishes of the Resident and their family. The End

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

of Life Assessment now includes Resident's wish regarding their place of death and their wish regarding care after death: to go home or stay here in Unit or remain in church overnight. All staff are aware of the need to get the family to sign the property form when they come to collect all personal belongings including money and jewellery.

Proposed Timescale: 31/07/2014