Centre name: Millbrae Lodge Nursing Home
Centre ID: ORG-0000419
Centre address: Newport, Tipperary.
Telephone number: 061 378933
Email address: info@millbrae.ie
Type of centre: A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider: Millbrae Lodge Nursing Home Limited
Provider Nominee: Linda Carew
Person in charge: Linda Carew
Lead inspector: Julie Hennessy
Support inspector(s): None
Type of inspection: Unannounced
Number of residents on the date of inspection: 76
Number of vacancies on the date of inspection: 5
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: 21 May 2014 08:30
To: 21 May 2014 16:00

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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Summary of findings from this inspection
This report sets out the findings of a thematic inspection which focused on two specific outcomes; end of life care and food and nutrition.

In preparation for the inspection, providers attended an information seminar, received guidance and completed self-assessment questionnaires relating to both outcomes to determine the level of compliance of the service in their centre. In the self-assessment questionnaire on food and nutrition, the provider nominee had determined that the service in the centre was compliant. In the self-assessment questionnaire on end of life care, the provider nominee had determined that the service in the centre was at the level of minor non-compliance.

Prior to the on-site inspection, the inspector reviewed the self-assessment questionnaires and policies relevant to both outcomes submitted by the provider nominee. On the day of the inspection, the inspector reviewed the centre's documentation pertaining to both outcomes and met with residents and staff and observed practice of the staff on the day. The inspector also reviewed survey questionnaires submitted by relatives of residents who had passed away in the centre. All questionnaires received indicated a high level of satisfaction with the care that these relatives' loved ones had received in the centre at the end of their lives.

On the day of the inspection there were 75 residents in the centre and one resident in hospital. The inspector found that compliance was demonstrated in both outcomes. Significant work had been completed by the provider nominee and the entire staff team since submission of the self-assessment questionnaires, particularly in the areas of end of life care planning and staff training.

The inspector found robust systems in place and evidence of good practice led by a
high standard of nursing care within both outcomes. As a result, the residents' end of life care and nutritional needs were substantially met.
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

#### Judgement:
Compliant

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

#### Findings:
The inspector found that care provided to residents at the end of their lives met the residents' expressed needs, took into account their individual wishes and was delivered in a respectful way.

The centre had a written end of life policy that was in date, comprehensive and gave good guidance to staff on the care of residents at the end of their lives. There was a system in place to ensure that staff read and were familiar with the policy and the inspector spoke with staff who were able to describe the procedures to follow before, during and after death, as outlined in the policy. Other relevant policies were in place and included the administration of medication via a syringe driver and administration of medication via subcutaneous butterfly injection.

Care practices and facilities were in place to enable the resident to receive care in a way that met their individual needs and wishes and respected their dignity and autonomy. End of life care plans had been completed over the previous few months for all residents except a very small number where residents and/or their families had declined to participate in the development of such a plan. In such cases, the person in charge was actively engaging with the residents and their families. Care plans reviewed by the inspector had been completed or updated within the previous 3 months, as required by the Regulations.

The inspector reviewed a sample of care plans, both for current residents and archived care plans for residents who had passed away. Overall, the inspector found that the physical, emotional, psychological and spiritual needs of the residents were clearly documented. For example, care plans specified how to control pain, ensure comfort, maintain skin integrity and details such as who the resident would like with them for emotional support, details of a particular priest known to the resident to contact and items that held sentimental value to the resident.
The inspector spoke with a number of residents who confirmed that they were involved in decisions about their own care and had been given the opportunity to express their preferences and wishes and also, to change their mind about their care or treatment options should they choose to do so. There were no complaints relating to end of life care in the complaints book.

While overall the care plans guided the care to be given to each resident towards the end of their lives, the inspector found that some needs were addressed more comprehensively than others. This was discussed with the person in charge on the day who was able to demonstrate an understanding of how to further develop the care plans.

The inspector found that religious practices were being fully facilitated; a priest visited the centre and said weekly mass, lay sacristans offered weekly communion and there was a pleasant and peaceful oratory in the centre. Residents confirmed that prayers were offered at the weekly mass for any resident who had passed away the preceding week.

At the time of inspection, there was no cultural diversity amongst the residents, although respect for other cultures was specifically addressed in the end of life policy and staff with whom the inspector spoke were aware of the policy content and how this might be translated into practice.

The inspector found that arrangements were in place to avoid unnecessary transfer to hospital, including nursing staff trained in the administration of medication via a syringe driver and subcutaneous injection. In this way, residents who were no longer able to take oral medication for pain relief could have their pain managed via other routes. Where a resident refused care, this was respected and clearly documented.

Residents had a choice as to their place of death where possible. Relative surveys reviewed by the inspector confirmed that residents had been offered choice as to their place of death. Residents’ preferences about whether they would be happy to go to hospital should their condition deteriorate were documented and the inspector spoke with residents who confirmed such conversations had taken place.

All residents were accommodated in single rooms. Family and friends were facilitated to be with the resident in their final days. The centre had a policy of non restrictive visiting times. There was a dedicated family room, where residents and relatives could stay overnight. The inspector viewed the room and found that it was warm and comfortable. A kitchenette was available where tea and coffee could be made. Relative surveys reviewed by the inspector confirmed that relatives had been offered the opportunity to stay overnight and had been offered refreshments.

Support and input from the palliative care team was available for residents who met the criteria for palliative care. The person in charge told the inspector that the palliative care team was very supportive. Records reviewed by the inspector confirmed the involvement of the palliative care team when required. There was no resident in the centre requiring that service at the time of inspection.
The person in charge confirmed that the general practitioner (GP) was involved in the resident’s end of life care plans. In addition, the person in charge described how the end of life care plans had been used by staff to convey the resident's wishes to on-call doctors in the event of a resident becoming unwell out-of-hours.

The inspector reviewed care plans of recently deceased residents and found that the needs of the residents had been closely monitored and the care plans reviewed to reflect any changing needs. For example, increasing needs relating to nutrition, hydration and ensuring comfort was documented and informed practice. There was evidence of frequent visits by the GP and constant review of medication, including analgesics for pain relief.

There were arrangements in place following a death of a resident and there were clear procedures in place to follow in relation to the verification and certification of death, including an unexpected death.

Respect was shown for the remains of a deceased resident. Specific arrangements were in place to ensure dignity and respect during such times, for example, staff described how they would maintain a quiet atmosphere and how special linen was used. The person in charge described how staff form a ‘guard of honour’ during the residents’ final departure from the centre. The inspector spoke with residents who confirmed that they were given the opportunity to pay their last respects, should they so wish.

There were arrangements in place to ensure that the removal of remains occurred in consultation with families. Relatives were facilitated to remain with their loved one until their remains were brought from the centre, should they so wish.

The inspector reviewed relative surveys that confirmed that information on how to access bereavement care and support had been offered. Where residents had been under the care of the palliative care team, follow-up and support by the palliative care team was also provided. Contact details for the coroner, undertakers and other religious ministers were provided. Information leaflets outlining supports for families following bereavement were prominently displayed at reception.

There were arrangements in place for the respectful packing and return of resident’s belongings and this was done in an unhurried way. The person in charge described how she would ensure that she met with all relatives when collecting personal belongings to offer support and any information the family may need.

A number of staff were trained in palliative care. The inspector viewed training records that demonstrated that the person in charge was committed to increasing staff training levels in end of life care across all staff grades. For example, three care staff had recently received training in end of life care and further training was scheduled this year. The inspector spoke with staff who were able to demonstrate learning from such training and what they would do differently following the training. The person in charge and assistant nurse manager were both working towards a European certificate in palliative care.
The inspector spoke with staff who confirmed that they were supported by the senior nursing staff and person in charge following the death of a resident. Where possible, staff members were facilitated to attend the removal or funeral mass of a resident. Support was available to other residents, staff and the deceased resident’s family from an in-house counsellor and the person in charge was also trained in counselling.

The inspector viewed the monthly newsletter, where a piece was dedicated to any recently deceased resident and included personalised information, such as where the person was from and who they were survived by. Minutes noted that the person in charge had discussed the planned introduction of end of life care plans at a resident’s meeting for residents.

On the day of inspection, the inspector observed sufficient numbers of staff on duty to meet the needs of the residents and observed that the care and interactions provided was appropriate and unhurried.

**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

**Judgement:**
Compliant

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

**Findings:**
The inspector found that the nutritional intake and needs of the residents were monitored and met to a high standard.

There were policies in place to guide staff in relation to meeting the nutritional needs of residents. Policies related to nutrition, the monitoring of nutritional intake, dysphagia, enteral tube feeding and the monitoring of resident fluid balance. The policies were concise and informative. Staff had signed to say they had read, understood and will comply with policies. The inspector spoke with staff and found that the policies informed staff practices.

The inspector reviewed a sample of residents’ files and found that each resident’s food, nutrition and hydration needs were assessed or screened at admission and the assessment included an oral health assessment. The inspector found that a formal system for ongoing oral health assessment was not in place, although the person in charge told the inspector that she is currently discussing such a system with the dentist who looks after the resident’s dental care. The inspector spoke with staff who described
how they carry out a visual oral health check of each resident on a daily basis and at mealtimes for any problems, such as loose dentures, sore gums or mouth ulcers.

The inspector found that comprehensive risk assessments had been completed using validated tools for eating, drinking and swallowing and each resident had a risk assessment completed of their risk of malnutrition. The inspector viewed a number of assessments and found specified dietary guidance, individual preferences and additional information such as the type of supervision needed.

Risk assessments for malnutrition were up to date and were completed at a minimum every three months. The inspector viewed a resident’s file that contained a 24-hour food chart, which was completed and maintained for three consecutive days, as outlined in the centre’s policy, where an issue of poor nutrition had been identified.

The inspector spoke with staff and found that they were able to describe signs and symptoms related to malnutrition or dehydration that might give cause for concern and the importance of reporting and recording such observations. For example, staff were able to describe the signs and symptoms of dysphagia.

The inspector found that assessments informed the development of care plans. Overall, care plans informed practice and the inspector observed staff implementing the care plans. Care plans had been reviewed within the previous three months, as required by the Regulations. The inspector reviewed residents’ files and found that at a minimum, monthly weights for all residents were recorded, and more frequently if required.

The inspector viewed a sample of residents’ records and found that residents had timely access to GP services and access to allied health professionals such as a speech and language therapist (SALT), dietician and dentist. Appointment records were maintained and outcomes of the appointments were clearly recorded with follow-up action taken as required. Input from the GP or allied health professionals was documented in the care plans and informed the care to be delivered.

In one of the files reviewed the inspector found a minor gap in documentation where advice contained in a report by the speech and language therapist was less specific in the care plan than in the SALT report. The inspector spoke with staff and found they were aware of the specific instructions of the SALT review. Nonetheless, the accurate documentation of specific advice is necessary to ensure consistency in practice.

The inspector found robust systems in place for the communication of residents’ preferences and any specific dietary needs to kitchen staff. For example, a daily diary was kept by the chef to note any resident who might be away from the centre at mealtime; a folder containing specific information about how each resident’s diet and preferences was kept in the kitchen and staff offices and breakfast cards were used to aid communication of residents’ dietary needs.

The person in charge described how all residents (including new residents) met with a member of the kitchen staff on both a one-to-one and group basis and residents with whom the inspector spoke confirmed this. The chef explained how residents were encouraged to give feedback on the food at mealtimes and this was also observed by
the inspector on the day of inspection. There were no complaints relating to food and nutrition in the complaints book.

There were three different dining areas in the centre; two were on the ground floor and catered for differing levels of assistance required by residents and the third was in the special care unit. The inspector observed breakfast and lunch in all three areas and sampled the food at both mealtimes.

The dining areas were observed to be pleasant, with table mats or tablecloths and condiments at each table. The atmosphere was unhurried with gentle music playing in the background. Residents had the choice of where they dined, with some residents choosing to eat in their bedrooms, the living room or the dining room. There was ample choice on the menu and staff were observed to offer choice to residents in relation to how liked their food or drinks prepared and served. Food was served hot where required and was well-presented. The food sampled was well cooked and appetizing. Where residents required assistance, this was done in an appropriate and discreet manner. Staff checked whether residents were satisfied with their meal and particulars such as whether they wanted sauce and had enough to eat. The inspector noted that the independence of all residents was maximised. However, the inspector noted that disposable napkins were used by residents, which were unattractive and resembled bibs. The person in charge demonstrated that she was addressing this issue and an order of cloth napkins had already been placed.

A kitchenette with tea, coffee and toast-making facilities and a fridge with yogurts was available on the first floor and was used by a small number of independent residents. The inspector completed a number of surveys on the day and spoke with residents who confirmed that meal times suited them and that snacks and drinks were available throughout the day and night.

The kitchen was clean and well organised. The fridge and freezer were well stocked with fresh meats, chicken, fish, fruit, vegetables and dairy products. Home baking took place on a daily basis and the inspector observed freshly baked scones. Menus demonstrated that the residents received a varied diet. Food was nutritious, for example, documentation demonstrated that organic red meat was sourced locally.

The menu for the day was written on a white-board in each dining area. The food options on the day corresponded with the menu for that day and there was a system in place to ensure that residents had a choice of foods or could have something of their own choosing.

The inspector reviewed the results of food surveys that had been organised in-house and completed by residents. Overall, the surveys indicated that residents were very happy with the quality, variety and quantity of food served. The chef and person in charge were responsive to suggested changes, for example, a number of residents requested that plain fish be sourced instead of breaded fish and action had been taken to meet this request.

Celebrations such as birthdays and other occasions were facilitated according to the resident’s wishes. There were facilities available to cater for different groups, with an art
room or lounge upstairs that were used to host celebrations, which family and friends attend.

There was sufficient staff on duty to meet the needs of the residents on the day of the inspection. Staff were assigned to different areas and there were additional ‘floating’ staff that moved between the three dining areas, the living room and the bedrooms to ensure that all residents needs were adequately met around mealtimes.

The inspector viewed staff training records and found that kitchen staff, nurses and care staff had all received training relevant to their roles. For example, training had been received in relation to modified diets, nutrition and dysphagia, nutrition and dementia and safer swallowing, nutrition and wounds. Also, the person in charge and all kitchen staff were trained in food hygiene and the person and change and some kitchen staff were trained in food allergy awareness.

The inspector spoke with the chef and found that he was very knowledgeable about the nutritional needs of the residents and was able to describe his learning from training, for example, how to fortify foods. The inspector spoke with carers and nurses who were knowledgeable about residents’ needs, likes, dislikes and preferences. Staff were able to describe different types of diets and how to correctly use thickening agents.

The inspector viewed the most recent environmental health officer reports that found a good standard of hygiene with up-to-date food safety records and a food safety management system in operation. Menu audits were completed by the dietician. The most recent audit in February 2013 contained a recommendation to introduce photographic prompts of food for the special care unit and the inspector viewed a folder containing such prompts that was near-completion. Food safety audits were completed by an external food safety consultant and the findings from the most recent audit in July 2013 were very positive.

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 the residents, relatives, and staff during the inspection.

Report Compiled by:

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