<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Borris Lodge Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000203</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Borris, Carlow.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>059 977 3112</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:jimmy@borrislodge.ie">jimmy@borrislodge.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Borris Lodge Nursing Home Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>James O'Keeffe</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Ide Batan</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>52</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
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About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

▪ to monitor compliance with regulations and standards
▪ to carry out thematic inspections in respect of specific outcomes
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 03 September 2014 12:10
To: 03 September 2014 18:00

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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<tr>
<td>Outcome 15: Food and Nutrition</td>
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Summary of findings from this inspection
This inspection report sets out the findings of a 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, received evidence-based guidance and undertook a self-assessment in relation to both outcomes. The inspector met residents and staff and observed practice during the inspection. Documents were also reviewed such as training records and care plans. The person in charge who had completed the provider self-assessment had judged that the centre was compliant in relation to both outcomes.

Residents described the provision of food and nutrition in positive terms and said that the food choices they were offered were very varied. There was good access to medical services including allied health professionals such as the dietician, dental speech and language therapist. The care plan documentation included care to be provided at end of life and the inspector found that there were plans in place for residents in the care plans viewed by the inspector. If staff had been unable to establish residents' own wishes and views this was recorded and family members had been consulted.

Residents who had dementia care needs or other neurological problems had care plans in place that were based on discussion with family members and staff knowledge of their wishes and preferences. There were systems in place to manage risk areas relevant to both outcomes. Staff had appropriate evidence-based policies and procedures to guide them in the management of unintentional weight loss, swallowing problems and significant changes in health care needs. There were systems in place to regularly audit practice.
Overall, the inspector noted that a warm, inclusive environment existed in the centre. Furnishings and housekeeping were of a high standard. Staff spoken with by the inspector exhibited an in-depth knowledge about the residents and their backgrounds and were observed caring for residents in a respectful manner while maintaining residents' privacy and dignity. Both the person in charge and provider displayed a commitment to the delivery of person-centred care and continuous improvement.

The inspector, found compliance in the area of Food and Nutrition and compliance in the area of End-of-Life care 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. As the provider was compliant with both outcomes pertinent to End of Life Care and Food and Nutrition there were no actions resulting from this inspection.
**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 2013 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(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The provider's self-assessment and overall self assessment of compliance identified compliance with Outcome 14 and Standard 16 of the National Quality Standards for Residential Care Settings for Older People in Ireland. The inspector reviewed the centre's policy on end-of-life care and noted that the policy was up to date, robust and comprehensive. It provided good guidance on the management of the period prior to death and the care of the body. It outlined procedures for end of life care and provided guidance for staff on care planning for end of life, consent, assessment of capacity, symptom control and how to provide support to relatives. Staff who spoke with the inspector were familiar with the policy. Training records indicated that the policy was also presented to all staff by a member of the nursing staff.

There was evidence that residents received care at the end of his/her life which met his/her physical, emotional, social and spiritual needs. Residents who spoke to the inspector spoke in a positive manner with regard to their care. Some residents expressed that in the event of becoming unwell, they would like to go to the acute services while other residents stated that they would prefer to stay in the centre. This information was captured in the residents' care plans.

Questionnaires, asking relatives' opinions regarding end-of-life care, were sent to the relatives of deceased residents. All responses reflected a high level of satisfaction with the care received. The inspector reviewed a sample of residents’ care plans with regard to end-of-life care and noted that they comprehensively captured residents' preferences at this time. Care plans were reviewed when updating a care plan, following a medical review or when a resident's condition changed. If a resident did require admission to hospital the inspector saw that there were transition documents available to support continuity of care between the hospital and the centre.

The person in charge told the inspector that residents did have the option of returning home for end of life care if they wished. However, to date this request had not arisen. Staff were knowledgeable in how to physically care for a resident at end of life and voiced how it was an honour to be there for the resident and their families at this time.
The inspector viewed four care plans of deceased residents and noted that staff were always with residents as they approached the end of their life. Care plans viewed indicated that residents had their end-of-life care needs addressed without the need for transfer to an acute hospital.

Nursing staff had all received training in reinsertion of percutaneous endoscopic gastrostomy tubes (PEG) and management of subcutaneous fluids. Other recent training pertinent to end of life care included education days on quality and end of life care, best practice in older person care, education programme in cancer care and 16 healthcare staff had completed a palliative care module in older persons. Nursing staff had completed Irish Hospice Foundation bereavement level one training.

Religious and cultural practices were facilitated. Residents had the opportunity to attend religious services held in the centre, and ministers from a range of religious denominations visited. The centre’s policy included guidance to staff with regard to facilitating and engaging in cultural practices at end of life. Staff told the inspector that a remembrance mass for deceased residents was held each year.

The staff team told the inspector that residents had very good access to the specialist palliative care services. This was a consultant led service which provided on site visits to residents and also advice via telephone. Staff had received training on the use of a syringe driver (a mechanical pump used to administer medications) in symptom management. There was good access to medical services as evidenced by the medical and nursing records. Documentation such as care plans reviewed by the inspector indicated that symptom control was effective for residents to ensure adequate pain relief and comfort at end of life.

Family and friends were facilitated to be with the resident at approaching and at end of life. The centre had a majority of single bedrooms with three two-bedded rooms. The shared rooms had adequate screening to promote privacy and dignity and ample space. Tea/coffee/snacks facilities were provided for relatives. Open visiting was facilitated. There was ample provision of private sitting spaces and sitting rooms. Overnight facilities for families were available if requested by families.

The person in charge stated that upon the death of a resident, his/her family or representatives were offered practical information (verbally and in writing by means of a leaflet) on what to do following the death and on understanding loss and bereavement and that this included information on how to access bereavement and counselling services. Nursing staff had completed bereavement level one training.

There was a procedure for the return of personal possessions. The inspector saw that all belongings are recorded and returned following the death of a resident. Staff outlined to the inspector that designed canvas bags were used to return personal possessions. The inspector observed these and other symbols used by the centre when end of life care was being provided.

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

**Findings:**
The inspector reviewed the person in charge's self-assessment questionnaire and the overall self assessment of compliance with Regulation 20 and Standard 19. The person in charge had assessed the centre as being compliant.

There were a range of well developed systems in place to ensure that residents had a good diet that was nutritionally balanced and provided in a manner that was appropriate to their needs. All residents had a nutritional assessment on admission and with information on their food preferences care plans for nutrition and hydration were drawn up. Care, nursing and catering staff worked together to ensure that information on residents' specialist needs were up to date and that appropriate food was available and prepared according to residents' requirements. Staff said that there were formal and informal arrangements in place such as regular team meetings to communicate changes in residents’ diets to catering staff who kept records of all individual requirements in the kitchen.

Residents had the option of having their meals served in their room or in the dining room and at a time of their choosing. The inspector observed that one care staff member had responsibility for monitoring residents who choose to have their meals in their rooms.

The inspector saw the service of the lunch time and evening meals. The chef served lunch from the bain marie which provided opportunities for her to engage with residents. It was evident throughout inspection that the residents were very familiar with the chef. There were two cooked choices available at lunchtime and there were many different options available at tea time. The dining tables were attractively presented and inclusive of good quality delph and cutlery. The dining tables were adorned with tablecloths, glassware and serviettes. Residents interviewed at this time said that the food was “always good” and “tasty”. The centre had a “protected meal time” arrangement in place which was supported by a procedure. This meant that visits and other activities were discouraged during meals except where relatives came to assist residents. This arrangement had been put in place to enable residents to eat in a quiet environment, at their own pace and it also ensured privacy and dignity was protected where residents needed help to eat.
Snacks and hot and cold drinks including juices and fresh drinking water were readily available throughout the day. The inspector noted that staffing levels were adequate to supervise meal times. There were three water dispensers available throughout the centre. Staff were observed assisting residents, particularly residents with a cognitive impairment, in a sensitive and discreet manner. Some residents had specialist cutlery which helped them eat independently. Meal times were unhurried social occasions and staff were observed using the mealtimes as an opportunity to communicate, engage and interact with residents.

The inspector met with the chef who confirmed that she met with the person in charge or the deputy to receive an update of the current status of the residents pertinent to their nutrition. Up-to-date information with regard to any changes in residents’ dietary requirements was available on a white board in the kitchen. The chef and staff who spoke with the inspector had in-depth knowledge of residents’ likes and dislikes. The chef told the inspector that she met most of the residents on a daily basis with regard to food preferences and residents who choose not to dine in the dining room were visited by the chef once per week. Picture enhanced communication in relation to food was also used for residents with cognitive impairment.

There were good working relationships with specialist services such as dieticians and speech and language therapists who were available on site. Nurses could make direct referrals for consultation to these services and from the records reviewed there was a timely response with regular and once off assessments undertaken. Access to diagnostic services was through the local hospital or outpatient department. Residents also had access to dental services and an assessment of dental care needs was included in the admission assessments.

The inspector noted that a dietician had recently assessed the menus and nutritional content of the food and noted that the menus were well balanced giving residents 6+ portions of carbohydrates, 5+ portions of fruit and vegetables, one portion of protein with each meal. In addition advice had been given in relation to samples menus, preparing the correct consistency, choices for those on a modified diet, low fat diets and food fortification.

The inspector saw that where residents had specialist needs related to swallowing, gaining or losing weight or variable eating patterns that care plans reflected the arrangements in place to meet their nutritional requirements. Specific safe swallowing guidelines were available for residents identified at risk. Validated nutrition assessment tools were used to identify residents at potential risk of malnutrition or dehydration on admission and were regularly reviewed thereafter. Records of residents’ food intake and balance were accurately completed. Residents were offered therapeutic or modified consistency diet as required following review by doctors, the speech and language therapist or dietician. The assessments and guidance from these professionals was recorded in care records, used to inform care plans which were reviewed on a regular basis as observed by the inspector. A sample of medication administration charts reviewed evidenced that nutritional supplements were prescribed by the general practitioner for residents were administered accordingly.
Residents' weights were recorded monthly or more often and it was evident that the documentation of a weight loss/gain prompted an intervention once a concern was identified including the commencement of food and fluid charts. Staff were knowledgeable with regard to the care of residents with a percutaneous endoscopic gastrostomy (PEG) tube and care plans reflected this. Residents with diabetes had a care plan guiding their care. The inspector noted information in residents' care plans regarding the recording of blood sugars and corresponding documentation of this information in residents' progress nursing notes.

The inspector reviewed records of residents' meetings. It was evident from minutes of these meetings that residents were satisfied with the food and choices provided. This was supported by the complaints log which did not include any concerns with regard to food. The daily menu was on display in a suitable format in the front foyer.

The inspector saw that meals were kept for residents who may miss a mealtime on occasions or an alternative meal was prepared. There were policies in place that provided guidance for staff on varied aspects of nutrition. These included:

- nutrition status and management
- risk factors for malnutrition in older persons
- the provision of specialist professional advice
- the management of hydration and fluid intake.
- nutrition and hydration care planning.

These policies were adhered to by staff. The inspector saw that nursing staff had completed training on the nutritional policy with other staff members.

Recent training that had been completed in relation to nutrition included:

- Nutrition and dementia
- safe eating dysphagia
- nutrition and wounds
- education on nutrition.

The catering staff had completed food hygiene training.

**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:

Ide Batan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority