Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Borris Lodge Nursing Home
Centre ID:	0203
Centre address:	Borris Co Carlow
Telephone number:	059-9773112
Email address:	jimmy@borrislodge.ie
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered providers:	James O'Keeffe
Person in charge:	James O'Keeffe
Date of inspection:	1 May 2012
Time inspection took place:	**Start:** 10:20hrs **Completion:** 19:30hrs
Lead inspector:	Noelene Dowling
Type of inspection:	☐ Announced ☒ Unannounced
Purpose of this inspection visit:	☐ Application to vary registration conditions ☐ Notification of a significant incident or event ☐ Notification of a change in circumstance ☐ Information received in relation to a complaint or concern ☒ Follow-up inspection

About the inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. These is to ensure that providers are complying with the requirements and conditions of their registration and meet the Standards, that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

National Quality Standards for Residential Care Settings for Older People in Ireland

Additional inspections take place under the following circumstances:

- to follow up matters arising from a previous inspection to ensure that actions required of the provider have been taken
- following a notification to the Health Information and Quality Authority's Social Services Inspectorate of a change in circumstance for example, that a provider has appointed a new person in charge
- arising from a number of events including information received in relation to a concern/complaint or notification to the SSI of a significant event affecting the safety or wellbeing of residents
- to randomly "spot check" the service.

All inspections can be announced or unannounced, depending on the reason for the inspection and may take place at any time of day or night.

All inspection reports produced by the Health Information and Quality Authority will be published. However, in cases where legal or enforcement activity may arise from the findings of an inspection, the publication of a report will be delayed until that activity is resolved. The reason for this is that the publication of a report may prejudice any proceedings by putting evidence into the public domain.

About the centre

Description of services and premises

Borris Lodge Nursing Home is a family run centre providing long-term, convalescent respite, and dementia care for persons over 65 years and younger persons with an acquired brain injury. There is accommodation for 52 residents.

The premises were originally a dower house built in 1885 and was first used as a nursing home in 1984. The premises were extended in two phases, once by the original owners and latterly by the present provider who took ownership in 2000.

The premises is a two-storey over basement construction, comprising of a ground floor which contains the reception area, nurse's office and adjoining dining room which is located in what was a conservatory and is bright and spacious. The kitchen, one large living room and three smaller living rooms, storage rooms and a sluice room are also located on this floor. Sleeping accommodation for residents on this floor comprises of 26 single bedrooms with en suite facilities consisting of assisted showers, wash-hand basin and toilet, and six single bedrooms with wash-hand basins. There are four assisted bathrooms on this floor.

The second floor, which is assessed via one of two lifts, comprises a living room, two single bedrooms with en suite, containing an assisted shower, toilet and wash-hand basin and one twin-bedded room with en suite, two twin bedrooms and 12 single rooms. The residents share two assisted bathrooms, one with medi-bath and toilet, one wet room with toilet, one bathroom with bath and two separate single toilets.

Windows are low level which allows residents to enjoy the views of the surrounding countryside. There are three courtyard areas on the ground floor which can be accessed easily by residents.

The basement contains a laundry room, meeting room, general storage, staff kitchen and changing room with showers and hairdressing room. The driveway and grounds are landscaped and well maintained.

Location

The centre is located in the village of Borris, Co Carlow in close proximity to all shops and amenities.

Date centre was first established:	2000
Number of residents on the date of inspection:	48*
Number of vacancies on the date of inspection:	2

* One resident in hospital

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	18	14	14	4

Management structure

James O'Keeffe is both the Provider and the Person in Charge. Helen O'Keeffe is the Director of Nursing. Kathleen Carrig is the Assistant Director of Nursing and deputises for the Person in Charge and the Director of Nursing in their absence. All nursing, care assistant, catering and cleaning staff report to the Director of Nursing. Maintenance staff report to the Person in Charge.

Staff designation	**Person in Charge**	**Nurses**	**Care staff**	**Catering staff**	**Cleaning and laundry staff**	**Admin staff**	**Other staff**
Number of staff on duty on day of inspection	1	3	7	3	2	1	2*

* 2 maintenance staff.

Background

This was the third inspection undertaken by the Authority in Borris Lodge Nursing Home and was a scheduled unannounced inspection. The registration inspection was undertaken on 29 and 30 June 2010 and 7 actions emanated from that inspection. On that inspection inspectors found that the centre was well managed. The day-to-day health needs of residents were met to a good standard with regular access to general practitioners (GP) services and reviews of healthcare. Good practice in relation to staffing levels and staff training were evident. The care was found to be person-centred with individual needs of residents being well met. The premises are fit for purpose. Areas for improvement were identified in relation to the care planning process, consultation with residents and relatives in regard to care planning and consent for use of methods of restraint, access to multidisciplinary services and detailed audits of accidents and incidents.

The provider's response to the report was prompt and satisfactory. A follow up inspection was undertaken on 8 February 2011. The findings of that inspection demonstrated that the provider had satisfactorily implemented the actions outlined in the registration inspection report and only two actions were identified on that inspection. the holding of fire drills on a twice yearly basis and ensuring that there were two qualified nurses on duty overnight taking account of the number and dependency levels of residents and the size and layout of the premises.

The provider was granted registration by the Authority on 10 December 2010 and this registration is due to expire on 9 December 2013 .The conditions attached to the registration at that time were that only persons over 65 years would be admitted, and only those younger persons with acquired brain injury resident at time of the registration inspection would be accommodated. These were the age range and category of care outlined by the provider in his application for regsitraion.. This inspection found that the provider had upheld all of the conditions attached to the registration.

Summary of findings from this inspection

This inspection took place over one day and was unannounced .The inspector examined fire safety records, maintenance records for equipment servicing, staff personnel files, complaints logs, training records, staff appraisal and induction records,accident and incident reports, audits, complaints records, residents medication records and medical records and residents care plans. The inspector spoke with a number of residents and staff and observed practices in the centre.

The findings of this inspection are presented under the headings "action required from previous inspections" and additional regulations covered on the inspection are identified under the section titled "other issues covered on inspection".

Both actions identified by the follow up report of February 2012 had been addressed satisfactorily by the provider. Fire management systems were generally good with regular servicing of equipment and staff training having taken place, although records of fire drills undertaken were not maintained. The nursing staff compliment overnight was sufficient.

This inspection found good practice in the recruitment of staff, induction and appraisal and the provider had continued to support training relevant to the needs of the resident population. Mandatory training was up to date. Residents' healthcare needs were met with regular review of residents and medication by the GP and promptly responded to by staff. Effective risk management strategies were identified and implemented. A schedule of activities tailored to the needs of the resident group and individuals was provided.

Some improvements were required in the documentation of a treatment plan for wound care and in the care planning documentation available.
The Action Plan at the end of this report identifies these improvements' that are required to comply fully with the 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*.

Issues Covered on Inspection

1. Health and Social Care needs

Inspectors found that resident's healthcare needs were well supported. Examination of four residents' care plans demonstrated that resident's healthcare and medication was reviewed as required and well within the three monthly timescale.
Out-of-hours services are provided and the daily nursing record maintained were detailed and provided evidence that staff were attentive, observant and responsive to the resident's health care needs.

Recognised assessment monitoring tools were used to assess the residents' health care needs including dependency levels, risk of pressure areas, nutritional assessments and moving and handling assessments. These were found to be regularly reviewed and changes responded to by referral to appropriate services or review. Staff spoken with were knowledgeable with regard to the residents' health care and status. Residents who were able to communicate with the inspector also confirmed that they saw their GP's regularly and that staff are responsive to their needs.

The resident population had diverse needs and a significant number have been assessed as maximum and high dependency. The care plans and records showed evidence that these diverse needs are recognised and supported, by a range of allied health services including psychiatry of old age and mental health specialists. Accidents are responded to by review of the relevant assessment, for example, moving and handling assessments were altered as required.

Observations of vital signs were undertaken monthly or as required for individual residents and action taken. For example, weight loss was carefully observed and referral to dietician or review with speech and language therapy and alteration to dietary instructions were made accordingly. A detailed and updated communication sheet is provided to the catering staff and this included instructions on the correct positioning of the residents during the meal and advice on the safe method of supporting the resident to take food. A significant number of the residents required assistance on a one-to one-basis with eating. The inspector observed that this was undertaken slowly and respectfully, and the inspector also observed staff ensuring that residents who could not access fluid themselves were supported to do so.

Suitable equipment such as pressure relieving mattresses are provided and instructions for repositioning residents at risk of developing pressure areas were detailed in the care plans. The nursing records confirmed that these are undertaken.

A number of residents required percutaneous endoscopic gastronomy (PEG) systems. Nursing staff were trained in the management of these systems which helped to avoid unnecessary admission to acute care for these residents.

The care plans demonstrated an understanding of the symptoms presented by residents, the reasons for some of the behaviours associated with these symptoms, and outlined interventions for staff in order to ensure an appropriate response. Staff were able to articulate these responses to the inspector.

However, the care plans and documentation were in the process of review and alteration and the inspector found the documentation fragmented and inconsistently detailed. For example, each resident's file contains a nursing intervention plan which outlines current health status, specific health needs, communication needs, recreational needs, preferences and underlying conditions. A problem identification and intervention document is then implemented, informed by the information in this plan. There was evidence that any changes were observed and documented. The plans were rewritten on a six monthly basis but there was evidence that the actual review took place as required or, on a three monthly basis. An admission assessment record had being compiled for immediate use which primarily detailed health care and nutritional needs and preferences. When fully implemented for new admissions this document is intended to support the residents' transition to the centre.

However, the entries in the care plans and problem identification sheets differed in the level of detail and instruction given. For example, the problem identification sheet for a resident with a pressure wound was generic whereas the details of the intervention for a resident with dietary symptoms and weight loss and a residents with cognitive impairment was very specific and provided a good guidance tool for staff. Similarly, some of the plans provided significant information on residents preferences and biographical information to inform the residents day-to-day life. Other care plans were very limited in this regard. The organisation of the documentation made it difficult to access and some changes to the plans were only recorded in the margins and not consistently dated.

One resident had been admitted from an acute care facility with a significant pressure ulcer. No other wounds were reported. The documentation in relation to the management of this was not cohesive. While the documentation showed evidence of assessment and monitoring it did not clearly outline the treatment plan to be implemented. The initial treatment was discontinued but the rationale for this was not clear, since the record showed evidence of improvement with this plan. The plan outlined a time frame for treatment and the documentation demonstrated that this was not adhered to. The inspector acknowledges that there was evidence of progress and improvement and pressure relieving mattress and a bed cradle was used to aid healing. However, the documentation did not clearly outline a treatment plan based on the assessment or guidelines for wound care.

The provider has employed a fulltime staff to undertake a range of activities suitable for groups and individual residents. A significant number of the residents were assessed as maximum and high dependency and a number also have a cognitive impairment. The Sonas therapeutic model is used and the dedicated staff had undergone training in implementing this. The inspector observed this being undertaken on a one-to-one basis with a resident and there was a further group activity held which residents enjoyed.

In addition to this, a care assistant was assigned activity duty for two hours each afternoon to provide support for residents who cannot participate in group activities. This work included supporting residents to walk around the premises or simply sitting with residents which was observed by the inspector. Other activities such as reminiscence and music were also provided. Items which have meaning for individual residents with cognitive impairment were observed being used and staff ensured that residents had access to them, for example, brightly coloured blocks. There is a weekly schedule for these activities to ensure all residents are included in the process. The location of the centre means that local events are acknowledged and community and familial links are maintained.

2. Safeguarding and safety

On an individual basis residents were assessed for risk of falls, or other accidents such as falling from bed or agitation which may lead to an incident and the safety of the use of any restrictive devises was evident and reviewed. There was evidence of consolation with relatives regarding the use of these devices. Preventative strategies were implemented such as low-low beds, censor alarms and staff supervision. Where bed-rails are deemed unsuitable due to the risk of the residents climbing over them these were removed and crash mats used if deemed necessary. The inspector also saw evidence that the use of such mechanisms ceases following review if the resident no longer requires them. Residents' independence was supported with access to assistive devices, and staff support to remain mobile. There was a commitment to balancing risks and the rights of residents to freedom of movement and choice evident.

The inspectors examined the accident and incident records and notifications forwarded to the Authority. This review found that individual incidents are responded to promptly, with alterations to manual handling procedures, staffing, use of bedrails, review of medication or illness being considered following a review of the incident by the person in charge or director of nursing. Changes to the plans or instructions were communicated to staff through handovers and team meetings and included in the care plans of the resident. Appropriate interventions were sourced following any incident with the resident's GP or out-of-hours service being contacted for review and vital signs monitored and observed.

There was continued evidence of audits of risk being undertaken including one on resident's care plans and records, medication management systems, falls and other incidents or accidents. The care planning audit took account of issues such as evidence of family consultation, review of assessment, signatures and dating of records. It identified some discrepancies and the medication audit also recommended and implemented changes.

The audit of falls and incidents was detailed and provided a good overview of incidents. However, the overall analysis and findings were not clear. For example, nine falls had occurred in June 2011.The audit did not analyse any factors which may have contributed to this outcome, such as time of day, staffing levels, or illness to promote ongoing learning and development overall.

Inspectors reviewed records which confirmed that equipment used for residents wellbeing and safety such as the hoists, beds, wheelchairs, call-bells and the lifts were serviced bi-annually and annually as required and the service records were current. The maintenance records demonstrated that any deficits or faults noted in equipment or on the premises were communicated in writing and remedied in a timely manner.

3. Suitable Staffing

Inspectors examined current and proposed rosters available and found that the skill mix of staff was suitable for the assessed needs of the residents and the size and lay out of the premises. Examination of the training records demonstrated a continued commitment to supporting training for staff. Mandatory training has been updated for staff in manual handling and fire safety. Training in the prevention, detection and reporting of abuse had taken place in 2011 for 39 staff and further training took place in February 2012. The training matrix identified any staff who required updates. Two further care assistant staff had completed Further Education and Training Awards Council (FETAC) level five training.

The provider was supporting two staff nurses to undertake an introduction to gerontology in 2012, nine staff had attended training in continence promotion in 2011 and 29 staff had completed training in the management of challenging behaviours. The director of nursing had completed Further Education and Training Awards Council (FETAC) level 6 in gerontology and supervisory management.

The inspector examined the personnel files of two of the most recently recruited staff and found good practice in recruitment. Both files contained all of the required documentation including evidence of current registration with An Bord Altranais, three references and completed Garda vetting and evidence of medical and physical fitness. The provider informed the inspector that all previously outstanding Garda vetting had been sourced. The provider was utilising a centre-specific and detailed reference request form which supports good recruitment, decision making and verification of information.

The inspector examined the staff induction checklist and found that it was detailed and specific to the role of the staff commencing employment. The induction takes place over a period of time and the inspector confirmed by interview and examination of rosters that the staff are given supernumery time under the direction of the assistant director of nursing and senior staff to become acquainted with the residents and the practices in the centre.

The provider had commenced a system of yearly performance reviews with staff and to date 29 staff had participated in the process according to the records available. The content as reviewed was relevant, focused on current practices, development needs of staff, and training relevant to the resident population. The content was tailored to each grade of staff participating in the process.

Actions reviewed on inspection:

1. Action required from previous inspection:

Ensure, by means of fire drills and practices at suitable intervals, that persons working in the designated centre and in so far as possible, residents, are aware of the procedure to be followed in the event of fire.

This action has been addressed. Inspectors examined the fire register and spoke with staff and found good practice in the management of fire safety. A detailed fire action diagram is available in a number of locations. In addition, an updated document detailing the resident's room numbers and whether they are independently mobile or require assistance of a wheelchair or slide sheet is maintained at reception. The purpose of this document was to provide detailed information to the fire service in the event that the premises had to be evacuated.

Records demonstrated that fire training for staff had been held annually and with the most recent held on the 22 February, 1 and 6 March 2012.The training included the use of fire fighting equipment and evacuation of residents using the fire compartment and slide sheets available. Staff spoken with were knowledgeable on the actions to take and the order in which the residents should be moved.

The fire alarm was serviced annually and tested on a three monthly basis. Emergency lighting, smoke alarms and fire fighting equipment were serviced annually. However, weekly as opposed to daily checks are undertaken on the fire alarm panel and exit doors. The provider stated that fire drills are held regularly and staff confirmed this. However, there was no written record of these drills maintained. Records and interviews confirmed that new staff employed had participated in the fire safety training.

2. Action required from previous inspection:

Ensure that the skill-mix of staff, with particular reference to nursing staff on night duty is appropriate to the assessed needs and number of residents.

This action was completed. Rosters examined confirmed that there were sufficient nursing staff, two, on duty overnight taking account of the residents' dependency levels and the size and layout of the premises.

Report compiled by

Noelene Dowling
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

3 May 2012

Chronology of previous HIQA inspections	
Date of previous inspection	**Type of inspection:**
29 June 2010	☒ Registration ☐ Scheduled ☐ Follow-up inspection ☒ Announced ☐ Unannounced
8 February 2011	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☐ Announced ☐ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report *

Centre:	Borris Lodge Nursing Home
Centre ID:	0203
Date of inspection:	1 May 2012
Date of response:	17 May 2012

Requirements

These requirements set out what the registered provider must do to meet the Health Act, 2007, 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*

1. The provider/person in charge has failed to comply with a regulatory requirement in the following respect:

Elements of the wound care management strategies and documentation were not inline with best practice and evidence based guidelines.

Action required:
Implement wound management procedures and documentation that are evidenced based and adhere to best practice guidelines in documentation and interventions.

Reference:
Health Act, 2007
Regulation 25: Medical Records
Regulation 8: Assessment and Care plan
Standard 11: The Resident's Care plan

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

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Wound care management strategies and documentation has been reviewed. Photographic evidence will be obtained of wounds on admission in the future and best practice guidelines followed.	Immediately

2.The person in charge has failed to comply with a regulatory requirement in the following respect: Care planning documentation was not maintained in a manner so as to ensure completeness, ease of retrieval and guidance for staff.	
Action required: Review the care planning system and documentation to ensure it is reflective of assessment, provides guidance for staff in addressing the assessed and identified needs of residents and that change's are clearly dated and reflected in the plans.	
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 11: The Residents Care Plan	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The care planning system and documentation will be organised so that assessments and guidance for staff are more clearly identified.	31 August 2012

3.The provider has failed to comply with a regulatory requirement in the following respect: All records pertaining to fire safety practices were not maintained.
Action required: Maintain a record of all fire drills which take place at the designated centre.
Action required. Maintain a record of daily checks on the fire alarm panel and exit doors.

Reference: Health Act, 2007 Regulation 32: Fire Precautions and Records Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Records of fire drills are presently maintained. All informal fire drill records will also be recorded and maintained. The weekly check and records on fire alarm panel and Exit doors will be changed to a daily record.	Immediately

Any comments the provider may wish to make:

Provider's Response:

The Inspection process was carried out in a professional informative manner. Areas of good practice were highlighted and areas for improvement are noted and acted upon. We find the inspection process an excellent external assessment of where we are and how we can continue to improve the services we provide to our residents.

Provider's Name: Jimmy O'Keeffe
Date: 17 May 2012