

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Sonas Nursing Home
Centre ID:	OSV-0000097
Centre address:	Cloghanboy, Ballymahon Road, Athlone, Westmeath.
Telephone number:	090 647 9568
Email address:	athlone@sonas.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Sonas Nursing Homes Management Co. Limited
Provider Nominee:	Seamus Crawley
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	Leanne Crowe
Type of inspection	Announced
Number of residents on the date of inspection:	53
Number of vacancies on the date of inspection:	3

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 19 July 2016 09:00 To: 19 July 2016 20:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Compliant
Outcome 03: Information for residents	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Substantially Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Substantially Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 14: End of Life Care	Substantially Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 17: Residents' clothing and personal property and possessions	Substantially Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This inspection took place in response to an application to change the entity of the centre. While there is a change of provider, the management structure and senior staff team in the centre remain unchanged. The change of entity also involves a change to the name of the centre from 'Sonas Nursing Home' to 'Sonas Nursing Home Athlone'. Inspectors also followed up on progress with completion of the action plans from the last inspection in the centre in March 2016. There were 13

actions from the last inspection, seven actions were satisfactorily completed. However findings on this inspection did not support satisfactory completion of six actions. These actions are restated in the action plan for this inspection.

Residents had satisfactory access to healthcare, medical and allied health professionals and their care needs were met. However, improvement was required with documenting residents' care needs and the interventions necessary to address their identified needs. Consultation with residents regarding their care plan reviews also required improvement.

The collective feedback from residents was one of satisfaction with the service and care provided. Community and family involvement was encouraged and residents confirmed that their visitors felt welcome at all times. Staff were observed to be respectful and responsive to residents at all times during this inspection.

While improvements had been made since the last inspection in March 2016, the findings on this inspection confirmed that further improvements are required in care planning, restraint management and staff training.

There was adequate staff numbers and skill mix to meet the needs of residents on the day of inspection with the exception of staff to co-ordinate activities. Inspectors found that the activities provided were varied and interested most residents. However, staffing resources were depleted due to unplanned leave and staffing levels were inadequate to meet the social and activation needs of residents.

The premises consisted of two floors, each providing accommodation for residents. The centre was purpose built and met its stated purpose. However residents' equipment was inappropriately stored in the refuge areas of emergency stair exits. A smoking area on a balcony, off the sitting room on the first floor also required review to ensure residents received fresh air through the windows opening out to the balcony area. Residents had access to a variety of communal rooms to meet their needs.

The Action Plan at the end of this report identifies improvements that must be made to meet the requirements of 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.

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

Outcome 01: Statement of Purpose

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There was a written statement of purpose available that accurately described the service provided in the centre and was demonstrated in practice.

A copy of the centre's statement of purpose and function dated 11 July 2016 was forwarded to the Authority. This document was reviewed and the inspector found that it contained all of the information as required by schedule 1 of the Regulations. The statement of purpose and function accurately described the range of needs that the designated centre meets and the services provided.

Judgment:

Compliant

Outcome 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The inspectors met with the providers, person in charge and deputy, the staff team and residents during the course of the inspection. The inspectors found adequate resources available to meet the needs of residents in terms of facilities, staffing, staff training and sufficient assistive equipment to ensure effective delivery of care in accordance with the centre's statement of purpose. There was a clearly defined management structure in place. Lines of accountability and authority were evident in addition to evidence that the providers worked with the person in charge on a consistent and supportive basis in the governance and management of the centre.

Management arrangements and monitoring systems were in place to review the quality of care delivered to residents and inform improvements. A report on the quality and safety of care delivered to residents in the designated centre for 2015 had been completed since the last inspection in March 2016 and was available for inspection.

Judgment:
Compliant

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

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

Findings:
The residents' guide was currently being updated, but a copy was made available to inspectors on the day of the inspection. This document was found to contain all of the necessary information required by the Regulations.

A sample of residents' contracts of care was reviewed by inspectors, all of which clearly stated details of any additional fees applicable to residents. While many contracts had been signed, either by the resident themselves or their representative, some contracts had not yet been signed. However, the provider demonstrated that any unsigned contracts were being followed up.

Judgment:
Compliant

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

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The centre was being managed by a suitably qualified and experienced nurse. She was accountable and responsible for the provision of the service. She is a registered nurse and has completed a post registration management qualification. She has many years experience of working with older people. The person in charge works full-time in the centre. During the inspection she demonstrated that she had knowledge of the Regulations and the Authority's Standards that governed residential/nursing care. She is supported in her role by an assistant director of nursing who takes charge in her absence and who also demonstrated appropriate knowledge and competence in relation to the Regulations. The assistant director, staff nurse team, carers, administration, maintenance, kitchen and domestic staff were accountable to the person in charge. Staff demonstrated their familiarity with the organisational structure. There was a structure of staff meetings which were minuted. The person in charge and her deputy work some of their duties at night to enable them to meet with night staff, assess how residents needs were met and to determine if night staffing levels are appropriate.

There were arrangements in place for the person in charge to meet with the provider. These meetings were formal and informal and the inspectors were told that there were good systems of communication in place and a joint effort made to ensure appropriate compliance with the Regulations and the Authority's Standards.

Judgment:

Compliant

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

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The majority of records listed in Schedules 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) were maintained to ensure completeness, accuracy and ease of retrieval. However, training records for staff were not accurately maintained on the day of the inspection. Records were updated following the inspection, but a robust system is required to ensure that these are maintained on an ongoing basis.

Written policies and procedures, as required by Schedule 5 of the Regulations, were available to inspectors. These were found to be reviewed and updated to reflect best practice and at intervals not exceeding three years. However, the policy for complaints required some improvement to ensure that it accurately reflected the centre's use of advocacy services.

A Directory of Residents was maintained in the centre and was found to contain the necessary information required.

Inspectors were informed that residents can access records pertaining to them.

Since the last inspection, a record of all visitors to the centre was being maintained in accordance with the Regulations.

Fire evacuation drills were completed reflecting day and night-time resources and conditions to ensure residents could be safely evacuated in an emergency. However, clarity in documentation of fire drills completed was required to reference staff involved in each drill.

Judgment:
Substantially Compliant

Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Governance, Leadership and Management

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

Findings:
There were arrangements in place for any absence by the person in charge.

The provider and person in charge were aware of their responsibility to notify the Chief Inspector of the proposed absence of the person in charge from the designated centre, the notifications that applied and the arrangements in place for the management of the designated centre during her absence.

Judgment:
Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
While there were measures in place to safeguard all residents from abuse, some improvements were required in relation to the management of restraint.

An action from the last inspection related to improvements required to ensure use of restraint was in line with the national policy was found to be in progress but not satisfactorily completed on this inspection. On the day of the inspection, bed rails were in use for a number of residents. Inspectors found that further improvement was required in bed rail assessments, particularly in ensuring that the rationale for implementing restrictive devices was clearly established and documented. In addition, where enablers were assessed as appropriate for some residents, improvement was required in the equipment provided to ensure that residents' independence was promoted at all times.

There were policies in place for the prevention, detection, reporting and responding to allegations of abuse. Training records indicated that staff had received training on the protection of vulnerable adults since 2015. There were no allegations of abuse under investigation at the time of the inspection; staff spoken with were able to describe their responsibilities to protect residents and to report any suspicions or allegations of abuse. Staff and residents confirmed that there were no barriers to them disclosing any suspicions or incidents of abuse.

There was a policy and procedure in place that promoted a positive approach to managing behaviours and psychological symptoms of dementia (BPSD). A number of staff had completed training in person-centred dementia care in 2015, and staff spoken with on the day of the inspection were knowledgeable regarding their responsibility to support residents with responsive behaviours. Inspectors observed staff to be kind and respectful towards residents in all of their interactions during this inspection.

There were systems in place to safeguard residents' money. The centre securely held money on behalf of a number of residents, and documentation was available to reference all transactions. A sample of balances of residents' money was reviewed by inspectors and these were found to be correct. New documentation had been introduced to record transactions in line with the centre's policy, and inspectors were informed that staff were in the process of phasing in these forms for all financial transaction records.

Judgment:
Substantially Compliant

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

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Inspectors' findings supported that systems were in place for promotion and protection of the health and safety of residents, visitors and staff on this inspection. The risk management policies to inform practices in relation to residents at risk of self-harm, violence and aggression, abuse and unexplained absence were in place. Residents at risk of leaving the centre unaccompanied were assessed and safeguarded. Staff participated in missing person drills to ensure their knowledge of the procedures to be followed in the event of a vulnerable resident leaving the centre unaccompanied.

Inspectors reviewed the centre's safety statement. A risk register was maintained informing environmental and clinical risk mitigation. Identification and assessment of risks with controls to prevent potential adverse incidents to residents, visitors and staff was documented. A system to monitor clinical outcomes was in place which provided an opportunity for learning and improvement. Arrangements were in place for reviewing, investigating and learning from incidents or adverse events involving residents. There was a low incidence of serious injury to residents from falling. Residents were assessed to determine their level of risk of fall and actions were identified to ensure that residents at risk of fall were kept safe and comfortable.

A fire safety register and associated records were maintained and precautions against the risk of fire were in place. Service records confirmed that the fire alarm system and fire safety equipment including emergency lighting and extinguishers were serviced appropriately and serviced on a regular basis. Identified issues for attention were being addressed. Fire doors and exits were checked on a daily basis as part of the fire safety checking procedures in place. However, inspectors found that areas on stairwells that served as emergency exit routes were used to store resident equipment. This finding posed a risk of obstruction to exiting the centre in the event of an emergency

evacuation being required. Progress with an action plan from the last inspection in March 2016 that referenced inspectors' findings regarding fire doors that were not fitted with a self-closure device and fire doors fitted with magnetic releases were seen to be held open by wedges were also examined on this inspection. Inspectors found that no fire doors were wedged open on the day of this inspection and a maintenance programme was underway to fit self-closure devices on all internal doors with the majority of doors completed.

Fire evacuation drills were completed reflecting day and night-time resources and conditions to ensure residents could be safely evacuated in an emergency. However, clarity in documentation of fire drills completed was required to reference staff involved in each drill. This finding is addressed and actioned in outcome 5. Emergency evacuation plans for safe were in place for each resident to support the centre's emergency policy. Fire safety training was completed by all staff, as confirmed by the staff training records and staff spoken with by the inspectors were knowledgeable regarding the procedures they should follow in the event of a fire.

The centre was visibly clean. Hand hygiene facilities were located throughout the premises. Environmental cleaning procedures were satisfactorily completed. An infection control policy was available to guide and inform staff.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

A policy was available to advise staff on management of residents' medications. Nurses were involved in transcription of residents' prescriptions which was completed in line with professional guidelines and prescribing legislation.

The centre's pharmacist was facilitated to complete their dispensing obligations to residents. There was evidence of auditing procedures completed by the pharmacist.

There were procedures in place for managing any medication errors in addition to return of unused and out of date medicines. There were no incidents of medication error recorded. Controlled medications were stored securely in a designated facility and stock-checking procedures were undertaken as required by staff.

While all residents' photographs were in place on prescription records, the quality of some photographs required improvement. The times on the prescription and administration record did not correlate and required address to ensure accuracy of these records. This finding is discussed and actioned in outcome 5.

Judgment:
Compliant

Outcome 10: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
A record of all incidents occurring in the designated centre was maintained and, where required were notified to the Chief Inspector. The inspector reviewed incidents of fall that had been recorded and found that incidents where a resident required further treatment in an acute setting were notified as required. The person in charge was aware of the notifications that had to be made to HIQA.

A quarterly notification report was forwarded to HIQA referencing details of required information up to March 2016 including use of restraint. Although recorded in the fire book, activation of the fire alarm on one occasion was not included in this report to HIQA as required. The person in charge advised inspectors that this information was omitted in error.

Judgment:
Substantially Compliant

Outcome 11: Health and Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily

implemented.

Findings:

There were 53 residents accommodated in the centre, three of whom were in hospital on the day of this inspection. 26 residents were assessed as having maximum dependency needs, 16 had high dependency needs and 11 had medium dependency needs.

Residents had good access to a choice of GPs, allied health professionals, palliative care and psychiatry of older age services. Residents' documentation confirmed they had timely access to these specialist services as required. Residents spoken with expressed their satisfaction with the care they received and the staff team delivering their care. Inspectors found that the healthcare needs of residents including residents with a diagnosis of dementia were generally met, however as found on the last inspection in March 2016, care planning required further improvement to ensure residents' needs were comprehensively assessed and documented to guide care practices. A physiotherapist was employed as part of the staff team and each resident was provided with physiotherapy as part of their care in the centre. A speech and language therapist and a dietician attended the centre as necessary and assessed residents with swallowing difficulties and residents at risk of unintentional weight loss. They set out recommendations to modify residents' foods/fluids or supplement their intake as appropriate. Recommendations made were documented in residents' care plans. Residents' weights were checked on a monthly basis or more often if necessary to facilitate closer monitoring and timely intervention.

While there was improvement in residents' care documentation since the last inspection in March 2016 found on this inspection, further improvement was required. The inspector found on this inspection that arrangements were in place to meet residents' assessed health and social care needs. Residents' care needs were assessed using validated risk assessment tools. While there were no deficits identified in the care residents were given, some residents' assessed care needs were not comprehensively documented in a care plan or needs identified lacked sufficient detail to inform consistent, appropriate staff interventions. Each resident had a holistic care plan completed reflecting needs following assessment within an 'activities of living' framework with additional care plans developed for other identified needs. However, improvement was required to ensure clarity regarding what needs should be addressed in additional care plans. Daily progress notes were all signed and dated by staff and were generally linked to care plans. Although staff documented their regular review of care plans, there was inconsistent documentation supporting concurrent consultation with residents and/or their next of kin to ensure the care and support provided reflected the assessed needs and wishes of residents.

Inspectors reviewed pressure ulcer preventative procedures and wound care management. There were no incidents of pressure related wounds occurring in the centre. Procedures to prevent pressure related skin injuries were satisfactory. Assessment of risk of skin breakdown was completed with equipment such as pressure relieving mattresses and cushions in addition to care procedures including repositioning used appropriately. Care of some residents admitted with wounds was also reviewed by inspectors. Inspectors found that although wound-care procedures were satisfactory, a

care plan was not documented to ensure comprehensive monitoring and consistent wound treatment interventions were undertaken. Tissue advisory specialists were consulted as necessary to support staff with management of wounds.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Effective care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The design and layout of the premises met its stated purpose; however, inspectors observed that there was evidence of insufficient storage for equipment in the designated centre.

The premises were found to promote residents' dignity, independence and wellbeing. The centre is a clean and brightly decorated, purpose-built two-storey building with accommodation for 56 residents in 55 single bedrooms and 1 twin bedroom. All bedrooms were en-suite with showers and toilets. There were also communal toilets and an assisted bathroom available on each floor. All bathrooms, shower rooms and toilet facilities contained grab rails to support residents. While there was sufficient storage for residents' belongings within their bedrooms, large items such as a hoist, laundry trolley and other assistive equipment were found to be stored in emergency exit stairwells.

Bedrooms were fully fitted with lighting and central heating, and contained suitable furniture and storage for residents' belongings. The bedrooms had adequate floor space to accommodate specialised or assistive equipment, should residents require same. Each bedroom contained a bed, wardrobe, chair, bed-table, telephone, call-bell and television. Lockable storage was also available in each bedroom. Residents were supported to individualise their bedrooms with personal items and furnishings, evidence of which was observed on the day of the inspection. Inspectors also observed that some bedrooms were individually identified to assist residents with dementia.

The layout of the centre supported freedom of movement of residents between common areas and their personal spaces. A spacious lift facilitated movement between both floors, and handrails in contrasting colours were fitted on all corridors. A variety of

paintings, photographs and other artwork were on display throughout the corridors. There were a number of communal spaces on both floors for residents including a reflection room, several sitting rooms and an oratory. An enclosed garden was also available to residents, which contained shaded seating and raised garden beds to support residents' recreational needs. A therapy room was located within the centre, which was also used by hair salon services. Signage around the centre supported residents to identify communal areas, as well as toilet facilities.

The sitting room on the first floor opened out onto a safe and secure balcony area along the only external wall to this sitting area. A small number of residents used the balcony area for smoking. While not found on inspection, there was a risk of cigarette smoke entering the sitting room through the open windows in this sitting room. The provider advised inspectors that this arrangement would be addressed as a priority. The provider had fitted an air cooler to ensure the comfort of residents resting in this area for use when weather temperatures increased. The air cooler was in use on the day of this inspection.

Laundry facilities were located within the designated centre and were found to be adequate to meet the needs of the residents.

Judgment:

Substantially Compliant

Outcome 13: Complaints procedures

The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There was a policy and procedure in place for managing complaints in the centre. A summary of the complaints' procedure was displayed in the reception area of the centre, and this was also included in the residents' guide document.

Complaint records detailed both formal and informal complaints and were made available to inspectors on the day of the inspection. These records contained the details of each complaint, the investigations completed and the outcomes and the actions taken.

There was a nominated person to deal with complaints, as well as an independent person to ensure that complaints were appropriately recorded and responded to.

Staff spoken with on the day of the inspection were knowledgeable of the complaints process, and could describe what action to take if a complaint was made to them.

Judgment:

Compliant

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:

There were no residents in the centre in receipt of end of life care on the day of inspection. A policy document was in place to inform care of residents at the end stage of their lives in addition to procedures relating to last offices.

Inspectors reviewed progress with addressing the action plan from the last inspection in March 2016 relating to a failure to consistently ensure timely communication with family and friends regarding deterioration in the condition of residents approaching the end of their lives. Inspectors found that there was improvement in practices since the last inspection and a review of deceased residents' documentation since the last inspection confirmed comprehensive communication with residents' families which ensured families were facilitated to be with residents during this time. Audits completed following the death of residents were available and maintained to inform improvements.

Community palliative services attended the centre as necessary to support residents with pain and symptom management on referral of residents by their GP. A sample of residents' end of life care plans were reviewed on this inspection. Most care plans reviewed were person-centred and informed staff regarding residents' wishes for their spiritual, psychological and physical care and the place they wished to receive that care. However, some improvement was required to ensure all residents were involved in this decision-making process.

There were arrangements in place to facilitate families to stay overnight in the centre with residents who were approaching the end of their lives. A small oratory was available in the centre. Residents had access to religious clergy to meet their faith needs.

The family and friends of each resident approaching end of life had not been consistently informed of the resident's condition, with the residents consent. This requirement is restated in this action plan.

Judgment:

Substantially 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:

Residents were provided with a nutritious and varied diet to meet their nutritional needs in a dining room on each floor. The centre has policies in place to inform management of residents' nutritional and hydration needs. The policies included evidence based practice and procedures to advise staff on nutrition/hydration assessment and meeting residents' needs. An accredited nutritional risk assessment tool was used to assess residents' needs. Residents' weights were regularly assessed, documented and closely monitored with corrective actions implemented where risk was identified.

Residents had access to dietician and speech and language therapy services as necessary. Residents with swallowing difficulties who required assistance were assisted discretely and sensitively on a one to one basis by staff who maintained eye contact on the resident to ensure their safety with eating. There was evidence that dietician and speech and language therapy specialist recommendations were implemented and were copied to the kitchen for reference by the chef. A head chef co-ordinated the catering service and met with inspectors on this inspection. She discussed innovative ways in which the catering team prepared and supplemented food for residents identified as being at risk of malnutrition to ensure their nutritional needs were met. The chef home-baked breads and confectionery in response to requests by residents. Inspectors saw that residents were offered a choice of hot meal and alternatives to the meals and deserts prepared as they wished. As the weather on the day of inspection was hot and sunny, the chef prepared a salad dish for tea as an alternative to the hot meal planned.

The dining rooms were attractively decorated in a traditional style. The dining room on the ground floor had access out into the garden. Each table in the dining rooms were dressed with table cloths and decorated with a flower centre-piece. A selection of condiments was available for use by residents to suit their individual tastes. The main kitchen was located on the ground floor and a kitchenette was located adjacent to the dining room on the first floor. Food was transported in a heated trolley to the kitchenette on the first floor and plated there before serving. A member of the catering staff remained in the kitchenette during mealtimes to ensure residents' nutrition needs were met. Arrangements were in place for recording individual residents' food and fluid

intake as necessary. The menu was displayed and was communicated to each resident by staff to ensure their informed choice regarding what they would like to eat. Residents spoken with by the inspector expressed their satisfaction with and enjoyment of the food provided. The chef was observed to mingle among residents during mealtimes and residents confirmed that if they were not enjoying their meal or did not like the food on offer, the chef would always prepare an alternative for them. Residents had a choice of fluids to drink with their meals, jugs of fresh water in their bedrooms and were offered hot and cold beverages and snacks throughout the day. The dietician was involved with the chef in menu planning and had completed an assessment of the residents' food provided to ensure it was nutritious and adequately varied. Records were maintained of food prepared for residents on a daily basis.

Judgment:
Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

Findings:
Residents were consulted in relation to the running of the centre with regular meetings convened and facilitated by the activity co-ordinator and feedback was used to inform improvement initiatives in the centre. The inspector observed that staff got consent from residents for care interventions and gave them choice regarding their daily activities in the centre. Residents had access to advocacy services.

There was a policy of open visiting in the centre with protected mealtimes. A variety of communal areas were available for residents to meet their visitors in private if they wished.

Inspectors found that residents received care in a dignified way that respected their privacy at all times during the day of inspection. Staff were observed knocking on residents' bedroom doors and closing doors to bedrooms and toilets during personal care activities. The inspectors observed that all staff interactions with residents were respectful, courteous and supportive.

Residents were facilitated to participate in activities in the sitting rooms on both floors.

While there was a good variety of activities that most residents enjoyed. However findings on this inspection supported improvements were required in assessment, documentation and provision of activity staff resources to ensure all residents' activation needs were met to reflect their interests and capabilities. The activity co-ordinator staff compliment was reduced due to unplanned leave and although the provider advised inspectors that arrangements for replacement were in progress, this had not been completed at the time of this inspection. Inspectors were informed that 15 residents had dementia in the centre. Although the activity co-ordinator and care staff was making every effort to meet the needs of residents in all areas of the centre, some residents' activation needs were not comprehensively assessed and documented especially residents with dementia.

Residents were facilitated to meet their religious/spiritual needs. A communication policy was available to inform staff on management of residents with communication difficulties. The communication of needs of residents was addressed in their holistic care plan. However, as discussed in outcome 11, documentation of interventions to be undertaken by staff required clarification and development.

Judgment:

Non Compliant - Moderate

Outcome 17: Residents' clothing and personal property and possessions Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

A policy and procedure was in place for the management of residents' property and possessions.

Residents had sufficient space to store clothing and possessions in their own rooms, and each bedroom also contained secure storage facilities for valuables. While detailed property logs were created on admission for each resident, these were not always up-to-date.

There were adequate laundry facilities in place for residents. While a tagging system was in operation for residents' clothing, a number of recent complaints related to items being mislabelled or misplaced in the centre following laundering. Records of complaints indicated that these items were located and returned to their owners, but the system requires review to ensure that residents' clothing is always returned to them.

Judgment:
Substantially Compliant

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

There were appropriate levels of staff to meet the needs of residents with the exception of sufficient staff to meet the activation needs of residents. The activity co-ordinator staff compliment was reduced due to unplanned leave and although the provider advised inspectors that arrangements for replacement were in progress, this had not been completed at the time of this inspection. Inspectors' findings confirmed that this was having a negative impact on residents in the centre, especially residents with dementia. There was a registered nurse rostered on duty at all times. An actual and planned staff rota for all staff was made available to inspectors.

Staff were found to be supervised appropriate to their role, and there was a comprehensive induction programme in place for recently recruited staff. Staff appraisals were ongoing at the time of the inspection, with records of these appraisals contained in staff files for those that had been completed to date for 2016.

A training needs analysis had been conducted for 2016 from staff appraisals in 2015. Training records indicated that all staff had completed mandatory training in fire safety, moving and handling practices and the prevention, detection and management of abuse. Inspectors spoke with staff on the day of the inspection, who were knowledgeable of the mandatory training they had undertaken. There was also evidence that some staff had completed training to support continuous professional development, including end of life care, infection control and falls education. However, inspection findings on inspection in March 2016 and on this inspection confirmed that staff training was required in care planning to support staff skills in comprehensively completing this process. In addition, training records for staff were not accurately maintained on the day of the inspection and this finding is discussed and actioned under Outcome 5.

A sample of staff files were examined by inspectors and were found to contain all of the necessary information required by Schedule 2 of the Regulations. Inspectors were provided with evidence to indicate that all nursing staff were currently registered with An Bord Altranais agus Cnáimhseachais na hÉireann.

While there were no volunteers working in the centre at the time of the inspection, a policy and procedure was in place for the recruitment of volunteers.

Judgment:

Non Compliant - Moderate

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:

Catherine Rose Connolly Gargan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

**Health Information and Quality Authority
Regulation Directorate**

Action Plan



Provider's response to inspection report¹

Centre name:	Sonas Nursing Home
Centre ID:	OSV-0000097
Date of inspection:	19/07/2016
Date of response:	30/08/2016

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

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

Review the complaints' policy to ensure that it accurately reflects the use of advocacy services in the centre.

1. Action Required:

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

¹ 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:

Complaints policy has been updated to provide contact details of SAGE, and contact details of our independent advocate. This information is also displayed on residents' information board on both floors.

Proposed Timescale: 30/08/2016

Theme:

Governance, Leadership and Management

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

Ensure that staff training records are accurately maintained at all times.

Clarity in documentation of fire evacuation drills completed was required to reference staff involved in each drill.

2. Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

- New training matrix in place to record staff training, this will be continually updated to reflect current staff and training completed.
- Fire evacuation drill recording sheets updated to include names of staff present at drills.

Proposed Timescale: 30/08/2016

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

Under Regulation 07(3) you are required to: Ensure that where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

3. Action Required:

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

- Policy has now been reviewed and fully compliant with the national policy as published on the Department of Health website
 - Where restraint is used it is only used in accordance with national policy
- Proposed Timescale: Completed and ongoing

Proposed Timescale: 30/08/2016

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

Areas on stairwells that served as emergency exit routes were used to store residents' equipment.

4. Action Required:

Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

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

- No equipment will be stored in these areas.
- Stairwells and emergency exits are checked by nurses every morning and night to ensure emergency exits routes are clear.

Proposed Timescale: 30/08/2016

Outcome 10: Notification of Incidents

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Activation of the fire alarm on one occasion was not included in this report to HIQA as required.

5. Action Required:

Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

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

Any incident where fire alarm is activated other than for training purposes will be notified at end of each quarter.

Proposed Timescale: Completed and ongoing

Proposed Timescale: 30/08/2016

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some residents' assessed care needs were not comprehensively documented in a care plan or needs identified lacked sufficient detail to inform consistent, appropriate staff interventions.

Improvement was required to ensure clarity regarding what needs should be addressed in additional care plans.

6. Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

All resident's needs are comprehensively documented in a care plan which includes detail to inform consistent, appropriate staff interventions.

Proposed Timescale: 01/10/2016

Theme:

Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

There was inconsistent documentation supporting consultation with residents and/or their next of kin to ensure the care and support provided reflected the assessed needs and wishes of residents.

7. Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

It is now clearly documented in all care plans who was consulted in compiling the care plans to ensure the care and support provided reflected the assessed needs and wishes

of resident

Proposed Timescale: 01/10/2016

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

Ensure that there is suitable storage on the premises for equipment, as required by Schedule 6 of the Regulations.

8. Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

Suitable storage will be created on the premises for equipment.

Proposed Timescale: 01/12/2016

Outcome 14: End of Life Care

Theme:

Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some improvement was required to ensure all residents were involved in the decisions made regarding their end of life care to ensure they had opportunity to express their wishes.

9. Action Required:

Under Regulation 13(2) you are required to: Following the death of a resident make appropriate arrangements, in accordance with that resident's wishes in so far as they are known and are reasonably practical.

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

- All residents have the opportunity to express their wishes and be directly involved in the decisions regarding their end of life wishes.
- Occasionally some residents do not wish to discuss end of wishes which we will document

Proposed Timescale: Completed and ongoing

Proposed Timescale: 30/08/2016

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

Improvements were required in assessment, documentation to ensure all residents activation needs were met to reflect their interests and capabilities.

10. Action Required:

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

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

An activities assessment will be used to ensure all residents activation needs are met to reflect their interests and capabilities.

Proposed Timescale: 01/10/2016

Theme:

Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Documentation of interventions to be undertaken by staff required clarification and development to ensure residents' communication needs were fully addressed.

11. Action Required:

Under Regulation 10(2) you are required to: Where a resident has specialist communication requirements record such requirements in the resident's care plan prepared under Regulation 5.

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

More detailed information is now included in the Multidisciplinary Plan of Care to ensure care plans are person centred

All Care plans are compiled in consultation with the resident where possible, or the next of kin.

Proposed Timescale: 01/10/2016

Outcome 17: Residents' clothing and personal property and possessions

Theme:

Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Review the systems in place to ensure that each resident's laundry is returned to them.

12. Action Required:

Under Regulation 12(b) you are required to: Ensure each resident's linen and clothes are laundered regularly and returned to that resident.

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

- Laundry process have been reviewed. Laundry supervisor has been appointed
- Property list to be updated as resident receives new clothing.
- All clothing is marked on admission by laundry staff.

Proposed Timescale: Completed and ongoing

Proposed Timescale: 30/08/2016

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Activity staffing resources required review to ensure residents activation needs were met.

13. Action Required:

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

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

Activity staffing levels have increased by 10 hours per week to meet the activity needs of residents. An activity programme is in place across the seven days

Proposed Timescale: Completed

Proposed Timescale: 30/08/2016

Theme:

Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Inspection findings confirmed that staff training was required in care planning to support staff skills in comprehensively completing this process.

14. Action Required:

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

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

- All Nurses has completed training in clinical documentation
- Auditing of care plans to be completed monthly
- Nurses will receive continuous mentoring and coaching in care planning for management

Proposed Timescale: Completed and ongoing

Proposed Timescale: 29/08/2016