

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Sonas Glendale Nursing Home
Centre ID:	OSV-0005417
Centre address:	Shillelagh Road, Tullow, Carlow.
Telephone number:	059 918 1555
Email address:	picglendale@sonas.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Sonas Nursing Homes Management Co. Limited
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	Leanne Crowe
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	48
Number of vacancies on the date of inspection:	12

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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 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: 05 December 2017 09:30 To: 05 December 2017 18:30

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Compliance demonstrated	Substantially Compliant
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Non Compliant - Moderate
Outcome 05: Suitable Staffing	Compliance demonstrated	Compliant
Outcome 06: Safe and Suitable Premises	Compliance demonstrated	Non Compliant - Moderate
Outcome 07: Health and Safety and Risk Management		Substantially Compliant
Outcome 08: Governance and Management		Substantially Compliant

Summary of findings from this inspection

This report sets out the findings of an unannounced thematic inspection which focused on specific outcomes relevant to dementia care in the centre. Inspectors also considered notifications and other relevant information and followed up on progress with completion of the action plans from inspection of the centre in April 2017.

The journey of a sample of residents with dementia within the service was tracked. Inspectors observed care practices and interactions between staff and residents who had dementia using a validated tool. Inspectors reviewed documentation such as nursing assessments, care plans, medical records and examined relevant policies including those submitted prior to inspection. All interactions between staff and residents observed by inspectors were respectful, supportive and kind.

The inspectors met with residents and staff members and residents who spoke with inspectors expressed their satisfaction and contentment with living in the centre. Inspectors found that the management team and staff were committed to providing a quality service for residents with dementia. While there was evidence of efforts made since the last inspection to ensure residents with dementia were supported and facilitated to enjoy a meaningful and fulfilling life in the centre, some further improvements were necessary.

Residents' accommodation in the centre was provided at ground floor level and residents with dementia integrated with other residents. The design and layout of the centre met its stated purpose with the exception of one communal sitting/dining room. Improvements to the layout of this room had been made since the last inspection but further work was needed to ensure the room and other areas of the centre met residents' needs and comfort. Otherwise the centre provided a generally comfortable and therapeutic environment for residents with dementia. Work was underway to improve accessibility with revised signage suitable for residents with dementia.

Documentation in relation to staff employment information and evidence of completed appropriate vetting procedures were complete. All staff had completed updated mandatory training requirements and were provided with opportunities to attend training to progress their professional development and skills. Staff spoken with were knowledgeable regarding residents and their care needs.

Inspectors found that the healthcare needs of residents with dementia were met to a good standard. There were policies and procedures in place to safeguard residents from abuse. All staff had completed up-to-date training in safeguarding residents from abuse, they were knowledgeable about the steps they must take if they witness, suspect or are informed of any abuse taking place. There were also policies and practices in place around managing responsive behaviours, and the use of restraint in the service and restraint management was found to be of a good standard with commitment demonstrated to achieving a restraint-free environment.

The Action Plan at the end of this report identifies areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland (2016).

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 Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

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

Findings:

This outcome sets out inspection findings relating to healthcare, nursing assessments and care planning. The findings in relation to social care of residents with dementia in the centre are covered in Outcome 3 in this report.

The centre catered for residents with a range of dependency needs. On the day of this inspection, there were a total of 48 accommodated residents in the centre. Twenty three residents had dementia and three residents had symptoms of dementia. Inspectors focused on the experience of residents with dementia on this inspection. They tracked the journey of a sample of residents and also reviewed specific aspects of care such as safeguarding, nutrition, wound care and end-of-life care in relation to other residents with dementia in the centre.

There were systems in place to optimise communications between residents/families, the acute hospital and the centre. The person in charge or senior nurse visited prospective residents in hospital or their home in the community prior to their admission. Some residents with dementia transitioned to continuing care from previous admissions for respite care. Prospective residents and their families were welcomed into the centre to view the facilities and discuss the services provided before making a decision to live in the centre. This gave residents and their families information about the centre and also ensured them that the service could adequately meet their needs.

A copy of the Common Summary Assessments (CSARs), which details pre-admission assessments undertaken by the multidisciplinary team for residents admitted under the 'Fair Deal' scheme, was maintained as part of residents' records. The details of pre-admission assessments completed by the person in charge or deputy were available in residents' files. The files of residents admitted to the centre from hospital also held their hospital discharge documentation. Transfer documentation was available that detailed information about the needs of residents transferring to hospital from the centre.

There was evidence that timely access to health care services was facilitated for all residents. The person in charge confirmed that a number of GPs attended to the needs of residents in the centre. Residents attended out-patient appointments and were

referred as necessary to the acute hospital services. Documentation reviewed and residents spoken with by inspectors confirmed they had access to GP care including out-of-hours medical care. Some residents who lived in the locality were facilitated to retain the services of the GP they attended prior to their admission to the centre. Residents had good access to allied healthcare professionals. A physiotherapist was employed by the provider and was available to residents as part of the service provided to meet their needs. Occupational therapy, dietetic, speech and language therapy, dental, ophthalmology and chiropody services were available to residents as necessary. Community psychiatry of older age specialist services attended some residents in the centre with dementia and supported their GPs and staff in the centre with managing their behavioural and psychological symptoms of dementia (BPSD) as necessary. Residents' positive health and wellbeing was promoted with regular exercise as part of their activation programme, an annual influenza vaccination programme, regular blood profiling and medication reviews. Residents in the centre had access to palliative care services for support with management of their pain and for symptom management during end-of-life care as appropriate.

There were systems in place to meet the health and nursing needs of residents with dementia. Assessments of residents' needs were carried out within 48 hours following admission and care plans were developed based on assessments of need and thereafter in line with residents' changing needs. The assessment process involved the use of validated tools to determine each resident's risk of malnutrition, falls, their level of cognitive function and skin integrity among others. Care plans were updated routinely on a three to four monthly basis or to reflect residents' changing care needs as necessary. Improvement was necessary to ensure residents or their family, as appropriate were consistently consulted regarding their care development and reviews. Inspectors found that all staff spoken with were knowledgeable regarding residents' likes, dislikes and care needs. Staff training, auditing and supervision of practices was undertaken to ensure assessment and documentation of residents' needs was maintained to a good standard. Since the last inspection in April 2017, improvements had been implemented in behaviour support care plans for residents predisposed to responsive behaviours. Residents' behaviour support care plans examined clearly informed behaviours experienced by each resident, triggers and effective person-centred interventions staff should use to de-escalate any BPSD. Assessment of each resident's needs was informed by the completion of relevant evidence based assessment tools. Residents' needs were informed by a person-centred holistic plan of care with additional care plans developed to inform their end-of life and behaviour support care needs. However, there was some care plan replication completed in generic format. This finding did not ensure that some residents' care plans reflected their individuality with person-centred care interventions to meet their care needs.

There was also improvement seen in activation needs assessments to inform the scope of residents' individual interests and capabilities especially residents with levels of dementia that impacted on their ability to participate and benefit from group activities.

Staff provided end-of-life care to residents with the support of their medical practitioner and the community palliative care services as necessary. While one resident received input from palliative care services, no residents were in receipt of end-of-life care at the time of this inspection. A pain assessment tool for residents, including residents who

were non-verbal was available to support pain management. Inspectors reviewed some end-of-life care plans for residents and found that they outlined the physical, psychological and spiritual needs of residents. Residents' individual wishes regarding location for receipt of end-of-life care were also recorded. Advanced directives were in place for some residents regarding resuscitation procedures. This documentation recorded family input on behalf of the resident in most cases in the records reviewed. Residents had access to an oratory in the centre. Each resident was accommodated in a single bedroom which supported their privacy during end-of-life care. Residents' relatives were facilitated to stay overnight with them when at the end-of-life stage of their lives. Staff outlined how residents' religious and cultural practices were facilitated. Members of the local clergy from the various religious faiths provided pastoral and spiritual support to residents.

There were care procedures in place to prevent residents developing pressure related skin injuries. Each resident had their risk of developing pressure sores assessed. Pressure relieving mattresses, cushions and repositioning schedules were used to mitigate risk of ulcers developing. Inspectors were told that no residents in the centre had a pressure related skin injury on the day of this inspection. The person in charge discussed care procedures for residents at risk of developing pressure related skin injuries, including the care of three residents with minor skin injuries which reflected evidence-based practice. Arrangements were in place to ensure the nutritional needs of residents who were at increased risk of developing pressure ulcers were reviewed by a dietician. Tissue viability specialist services were available to support staff with management of pressure wounds that were deteriorating or slow to heal. A policy document informed wound management. Inspectors reviewed wound management procedures in place for a resident with a minor wound. Wounds were photographed and wound dimensions were measured to monitor progress with healing and a treatment plan informed dressing procedures.

There were systems in place to ensure residents' nutritional needs were met and that they did not experience poor hydration. Improvements in dining arrangements were implemented since the last inspection to ensure residents had adequate space and that they could dine at a table if they wished. A nutrition policy was available and informed practice. Residents were screened for nutritional risk on admission and were reviewed regularly thereafter. Residents' weights were checked routinely on a monthly basis and more frequently where residents experienced unintentional weight loss. Nutritional assessment and care plans were in place that outlined the recommendations of the dietician and speech and language therapist where appropriate. Systems were in place for recording and monitoring residents' nutrition and fluid intake where required. Procedures were implemented since the last inspection to clearly inform necessary fluid intake over 24 hours for residents at risk of dehydration. Residents had a choice of hot meals for lunch and tea. Feedback from a resident menu satisfaction survey was used to inform the menu options provided. Residents with dementia were supported to make informed choices regarding the menu on offer. Alternatives to the menu on offer and snacks and refreshments were also provided. There were arrangements in place for communication between nursing and catering staff to support residents with special dietary requirements. Inspectors observed that residents on special diets and thickened fluids received the correct diets and drinks. Staff supported and provided discreet assistance to residents with eating their meals as necessary.

There were arrangements in place to review accidents and incidents involving residents in the centre. Residents were assessed on admission and regularly thereafter for risk of falls. There was evidence of identification and implementation of learning from reviews of falls. HIQA was notified of two incidents of resident falling and sustaining a fractured bone since the last inspection in April 2014. Procedures were put in place to mitigate risk of further falls and residents at risk of falling were appropriately risk assessed with controls such as hip protection, increased supervision and sensor alarm equipment put in place. The centre's physiotherapist reviewed all residents who experienced a fall to ensure their mobility and independence was safely optimized.

There were written operational policies informing ordering, prescribing, storing and administration of medicines to residents. Inspectors found that practices in relation to prescribing, administration and medication reviews met with regulatory requirements. The maximum dosage of PRN (a medicine only taken as the need arises) medication permissible over a 24 hour period was stated by the prescriber. Medicines to be administered in a crushed format were not individually identified on prescription records. Inspectors observed that staff were trained to administer subcutaneous fluids to treat dehydration in order to avoid unnecessary hospital admissions. No residents were prescribed subcutaneous fluid administration on the day of this inspection. The person in charge told inspectors that the pharmacist who supplied residents' medications was facilitated to meet their obligations to residents. However, records of audits completed by the pharmacist were not available in the centre. There were procedures for the return of out of date or unused medications. Systems were in place for recording and managing medication errors. Medicines controlled under misuse of drugs legislation and medicines requiring refrigerated storage were appropriately managed. Balances of controlled medicines were checked as required and balances checked by an inspector were correct. Monitoring of medication refrigerator temperatures was in place.

Judgment:

Substantially Compliant

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

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

Findings:

Procedures were in place to protect residents with a diagnosis of dementia and all other residents from being harmed or suffering abuse. A policy was available to inform staff on management of any allegations, suspicions or incidents of abuse to residents. This policy was recently demonstrated in practice in response to an allegation of abuse which was reported to the Health Information and Quality Authority (HIQA) as required. There were systems in place to ensure that allegations of abuse were investigated, and that pending such investigations measures were in place to ensure the safety of residents.

Inspectors observed that all interactions by staff with residents were respectful, supportive and kind. Residents spoken with on the day of inspection expressed their satisfaction with the care they received, staff and their safety in the centre. Staff training records available to inspectors referenced that all staff had received training on prevention of abuse and safeguarding vulnerable residents. Staff spoken with by inspectors were knowledgeable regarding types of abuse and their responsibility to report any allegations, suspicions or incidents of abuse. There were no allegations or incidents of abuse under investigation at the time of this inspection.

Some residents with dementia experienced behaviours and psychological symptoms of dementia (BPSD). Their responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) were managed to a satisfactory standard with appropriate person-centred supports. Inspectors observed that staff approached residents predisposed to dementia with compassion and patience. The interventions they utilized to de-escalate any evidence of the behaviours were person-centred and were informed by residents behaviour support care plans. Most staff had attended training on dementia care and managing associated behaviours.

There was evidence that staff were committed to and working towards achieving a restraint-free environment. A policy informing the use of restraint was available and was demonstrated in practice. The person in charge and staff were working towards reducing the use of bedrails in the centre with low-low beds, additional equipment and further education for staff. Inspectors were told that there were no residents receiving PRN (a medicine only taken as the need arises) psychotropic medicines to de-escalate responsive behaviours. Procedures were in place to ensure use of PRN psychotropic medicines were reviewed. Bedrails were currently being used for a small number of residents, some of whom requested them to support their mobility and comfort while in bed. There was evidence of alternatives tried to ensure full-length bedrail use was appropriately applied. .Appropriate 'enabler' equipment was also available and used where possible as an alternative to full-length bedrails. Assessment of bedrail use was completed to determine need and to ensure safety of use in each case. Safety checks were completed each time the bedrail was applied.

The provider did not act as a collection agent for any residents' social welfare pensions. The provider did not maintain any residents' money in safekeeping on their behalf for their use for day-to-day expenses. Residents had a lockable space in their bedrooms to secure their personal valuables if they wished. Access to the centre was controlled by staff and a record of all visitors to the centre was maintained.

Judgment:
Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

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

Findings:

Since the last inspection in April 2017, inspectors found that improvements had been implemented to provide a comprehensive activity programme for all residents including residents with dementia. All residents, particularly those with dementia, were supported to engage in activities that supported their capabilities, interests and preferences. One full-time activity co-ordinator and one-part time activity co-ordinator were responsible for developing the centre's activity programme. Since the previous inspection, activity staff had completed training that supported them to provide activities dedicated to residents with dementia. Inspectors found that care staff were now deployed to support activity staff or to independently carry out their own activities. This facilitated activity staff to also carry out dedicated one-to-one activities and smaller group activities. On the day of the inspection a variety of activities were being provided in both sitting rooms; including bingo, therapeutic activities, prayers, hand massage therapy and manicures.

A new system for documenting residents' participation in activities was being trialled at the time of the inspection. While the 'tick-list' record was still being completed at this time, inspectors were informed that the new system would be fully implemented at the beginning of 2018. This new system evaluated residents' engagement in activities in a simplified manner, and would support staff to deliver an activity programme that met the capabilities and interests of each individual resident, particularly those with dementia.

Although inspectors did not observe residents using the sensory room on the day of inspection, they were told that this was now used regularly by residents for activities and as a quieter sitting room. Activity co-ordination staff used this room for smaller group activities and sensory-based activities that catered to residents with dementia.

Inspectors observed the quality of interactions between staff and residents using a validated observational tool to rate and record these interactions at five minute intervals in both dining-rooms and two sitting-rooms. Scores for the quality of interactions are +2 (positive connective care), +1 (task orientated care), 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). The scores reflect the quality of the interactions with the majority of residents. Inspectors' observations concluded that on this inspection, the majority of interactions on a one-to-one basis were graded as positive connective care with some instances of task-orientated care. Inspectors acknowledged that this represented an overall improvement in interactions between staff and residents. Further work was required to ensure that all residents' interests and capabilities were met in some group situations. For example, during one of the 30 minute observations carried out by inspectors, one member of staff was carrying out hand massage while the other residents in the group were not meaningfully occupied as they could not all view the television due to the layout of the room. Inspectors were told that plans were at an advanced stage to reconfigure the layout this sitting-dining room.

Inspectors found that a revised communication policy now included the relevant guidance for staff regarding communication with residents with dementia. Communication aids and devices were used by residents and care plans were in place to support them. Telephones were available in all bedrooms, and televisions throughout the centre had been upgraded with a digital service to enhance viewing for residents. Wireless internet was available in the centre, although residents had informed management that there were issues in one area of the building. Work was ongoing at the time of the inspection to remedy this and was expected to be rectified.

The inspectors observed that residents' privacy and dignity was respected by all staff members. Staff sought consent from residents for all care activities and facilitated their choices regarding their daily routine. Residents were supported to receive visitors in private if they wished in a number of quiet areas available throughout the premises. While visiting was not restricted to particular times, visiting was discouraged during mealtimes in order to adequately support residents.

Residents were consulted with and participated in the organisation of the centre. A residents' forum was held on a regular basis, and minutes of these meetings were available for review by inspectors. The meeting minutes indicated that residents' opinions were sought in relation to activities, plans for the centre and other issues. For example, residents were satisfied with a new 'Knitting Club' that had been established in the centre a number of months prior to this inspection.

Hairdressing services were available to residents on a weekly basis, and these were provided in a dedicated therapy room.

Residents with dementia were supported to observe or abstain from religious practice in accordance with their wishes. An oratory was located in the centre to facilitate religious services and a mass from a local church was now broadcast every morning in the main sitting room. Residents were visited by clergy from their respective faiths regularly.

Advocacy services were available to residents if required.

Judgment:

Non Compliant - Moderate

Outcome 05: Suitable Staffing

Theme:

Workforce

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

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

Findings:

Inspectors' observations throughout the day of this inspection provided assurances that sufficient numbers of staff were available and appropriately allocated to ensure each resident's care, supervision and activation needs were met. Inspectors acknowledged

significant improvements had been made since the last inspection to ensure residents' were provided with and supported to participate in activities that meet their interests and capabilities. Inspectors spoke with residents during the inspection and they spoke positively about staff availability. Residents also expressed their satisfaction with how their activation needs were met and the timeliness with which they were assisted with their personal care needs.

A planned and actual staff rota was in place, with changes clearly indicated. The roster reviewed by inspectors reflected the staff on-duty on the day of inspection. A number of new care staff were recruited and were undergoing role induction. The management structure was also undergoing revision to strengthen support for the person in charge with clinical supervision.

There were policies and procedures in place to inform staff recruitment, training and development. An induction handbook was available for newly-recruited nurses, and an induction programme was in place for all staff grades. The person in charge informed inspectors that probation assessments were completed at the first, third and sixth month of employment. An annual appraisal process was in progress.

A sample of staff files were reviewed by inspectors, and these were found to contain all of the information required by Schedule 2 of the regulations, including evidence of completed An Garda Síochána Vetting.

A staff training programme was in place. Staff training records and staff spoken with confirmed that mandatory training requirements were facilitated. Staff were also facilitated to attend training to support their professional development.

Minutes made available to inspectors confirmed that the person in charge met various staff grades on a regular basis.

Inspectors were informed by the person in charge that there were no volunteers operating in the centre at the time of the inspection.

Judgment:
Compliant

Outcome 06: Safe and Suitable Premises

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:
The centre is a single storey premises. Residents' accommodation in the centre consists of 60 single bedrooms with en-suite toilet, shower and wash basin facilities. Residents

had access to two dining rooms, one of which was designed in a sitting/dining room style with kitchenette facilities. Inspectors noted that some improvements made to the layout of areas of the premises since the last inspection provided a more therapeutic and accessible environment for residents with dementia. The layout of this sitting/dining room had been reconfigured since the last inspection:

- seating was no longer arranged in front of a door to the enclosed garden, making it more accessible to residents
- the dining room was observed to be less crowded at mealtimes, which improved the dining experience for residents
- a larger television had been purchased and moved to a more central space within the main sitting room area to make it visible to more residents.

Inspectors did not observe any inappropriate storage of equipment in the sensory room on this inspection.

While the layout of the sitting-dining room area had been reconfigured to give residents sufficient space to participate and engage in recreational activities and dine comfortably. A large screen television was also fitted in this room however, the layout of the room continued to hinder some residents' television viewing. Inspectors were informed that additional internal structural works was planned for the room in the near future to further enhance the environment for residents.

As found during the last inspection, there was a significant malodour in a room used for storage of residents' equipment that was also evident in the corridor immediately outside this room. Floor surfaces on corridors in some areas were uneven and carpeting was worn and stained. Inspectors were informed that action had been taken to address the uneven floor surfaces and the cause of the malodour, but had not been successful.

A larger sitting room was located to the front of the premises, and this was used throughout the day of the inspection for recreational activities and for televising mass from the local church. While some seating had been available at the reception area at the time of the previous inspection, additional furniture had been placed here and residents, relatives and other visitors were observed to be availing of this space throughout the inspection.

A therapy room was located in the centre, which was used by staff and external service providers for various treatments including hairdressing.

Two enclosed communal courtyards and an enclosed garden area were provided for residents' use. The courtyards were easily accessible to residents and one courtyard contained a number of raised flower and vegetable beds and a sheltered smoking area. At the last inspection it was noted that the enclosed garden had not been adequately maintained and was not safe and accessible to residents. Inspectors found on this inspection that the maintenance issues had been addressed: the pathways had been cleared, shrubbery had been attended to, the pond had been cleaned and fencing had been mounted around the pond. This fencing had been painted in vibrant colours by a number of staff members. While poor weather on the day of the inspection resulted in the garden not been used by residents, management informed inspectors that the garden had been used throughout the year, and further activities in the garden were planned for 2018. Handrails were located on all corridors and in showers and toilets.

Bedrooms were equipped with a locker, chest of drawers, a wardrobe, a chair, a television and a bed for each resident. Inspectors observed that many residents had personalised their bedrooms with personal possessions and small items of furniture from their home. Inspectors were told that residents were encouraged to make their room 'their own' and to use items of their own furniture if they wished to enhance their comfort.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

Theme:

Safe care and support

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

This was the centre's first inspection by the Authority.

Findings:

This outcome was not assessed in full at this inspection.

The storage of cleaning agents in the centre's therapy room was not in line with the measures and actions as outlined for safe storage of hazardous materials in the centre's risk register.

A risk register was operational in the centre which identified controls around the safe storage of chemicals. However, inspectors found that on the morning of the inspection the therapy room was unlocked and two cleaning agents that posed a risk to residents were stored on open shelving. Inspectors were not assured that the storage of these cleaning agents and chemicals was in line with the controls outlined in the centre's risk register.

Judgment:

Substantially Compliant

Outcome 08: Governance and Management

Theme:

Governance, Leadership and Management

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

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

Findings:

There was a clearly defined management structure in place and this reflected the information outlined in the centre's statement of purpose. Lines of authority and accountability were defined and all members of the team spoken with were aware of

their roles, responsibilities and their reporting procedures. Governance meetings were attended by the provider and minutes were made available to inspectors. Team communication was promoted by the person in charge with regular meetings convened with the various staff grades.

Systems were in place to monitor the quality and safety of the service and the quality of life for residents. There was evidence that review of the service informed a number of improvements that positively impacted on the quality of care and life of residents in the centre. However, improvements were necessary to ensure a the monitoring system in place comprehensively informed continuous quality improvement in the centre. For example, there was an absence of evidence that progress with a number of action plans developed from analysis of audits was comprehensively reviewed and tracked to completion.

The provider and clinical management team demonstrated that they welcomed feedback on the service provided from residents and relatives. The inspectors saw that areas for improvement raised in a recent satisfaction survey were actioned by the provider and person in charge with positive outcomes for residents in the centre. For example, new signage erected was improved. Feedback from residents and relatives spoken with on inspection was positive.

Inspectors found that there were sufficient resources provided to meet the needs of residents on this inspection.

Judgment:
Substantially 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:

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

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Regulation Directorate**

Action Plan



Provider's response to inspection report¹

Centre name:	Sonas Glendale Nursing Home
Centre ID:	OSV-0005417
Date of inspection:	05/12/2017
Date of response:	04/01/2018

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 01: Health and Social Care Needs

Theme:

Safe care and support

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

There was some care plan replication completed in a generic format. This posed a risk of confusion in the care information documented and did not ensure that some residents' care plans reflected their individuality with person-centred interventions to meet their care needs.

1. Action Required:

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

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:

This care plan was a discontinued care plan(UTI) which is now removed, all care plans reviewed to ensure person centeredness

Proposed Timescale: completed and ongoing

Proposed Timescale:

Theme:

Safe care and support

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

Improvement was necessary to ensure residents or their family, as appropriate were consistently consulted regarding their care development and reviews.

2. 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:

Resident family involvement in four monthly reviews is documented accurately. Four monthly review record sheets now changed to include a section to identify family involvement.

Proposed Timescale: completed and ongoing

Proposed Timescale:

Theme:

Safe care and support

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

Some medicines were administered in a crushed format which was not the administration format indicated on their prescription records.

3. Action Required:

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

All Prescription sheet reviewed by PIC and GP

All medication which is to be crushed is charted as crushed. Same communicated to all RN

Proposed Timescale: 04/01/2018

Theme:

Safe care and support

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

The pharmacist who supplied residents' medications was facilitated to meet their obligations to residents. However, records of audits completed by the pharmacist were not available in the centre.

4. Action Required:

Under Regulation 29(2) you are required to: Facilitate the pharmacist concerned in meeting his or her obligations to a resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland.

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

Requested pharmacist to keep audit sheet in the centre. Audit completed by Pharmacist

Proposed Timescale: completed and ongoing

Proposed Timescale:

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

Further improvement was required to ensure that all residents were provided with opportunities to engage in activities in line with their interests, preferences and capabilities.

5. 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:

Activities for all residents that meets their needs are in place.

Proposed Timescale: completed and ongoing

Proposed Timescale:

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

There was a significant malodour in a room used for the storage of residents' wheelchairs and other transport equipment.

Some floor surfaces on circulating corridors were uneven.

Carpeting on some corridors was worn and stained.

6. 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:

Malodour repaired by maintenance man, builder will repair it further before 31 January 2018.

Uneven surface is corrected by Maintenance man, builder will repair it further by 31/1/18

A first phase six-month carpet repair plan in place for 2018.

Proposed Timescale: 30/06/2018

Outcome 07: Health and Safety and Risk Management

Theme:

Safe care and support

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

The storage of cleaning agents in the centre's therapy room was not in line with the measures and actions outlined in the centre's risk register.

7. Action Required:

Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

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

Cleaning agents removed from the room and stored appropriately as per Sonas policy.

This risk is now included in hazard identification and risk register. Risk is Communicated to relevant staff to ensure proper storage of chemicals and cleaning agents.

Proposed Timescale: 04/01/2018

Outcome 08: Governance and Management

Theme:

Governance, Leadership and Management

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

Improvements were necessary to ensure a the monitoring system in place comprehensively informed continuous quality improvement in the centre

8. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

Audits outcomes communicated to all staff in meeting and hand overs. An action plan is developed as a result of all audits. A follow up audit of Audit action plan is completed by PIC to ensure all actions are completed in a timely manner. Audit outcomes are discussed in monthly Management meeting.

Proposed Timescale: completed and ongoing

Proposed Timescale: