Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Sonas Nursing Home Cloverhill
Name of provider:	Sonas Nursing Homes Management Co. Limited
Address of centre:	Lisagallan, Cloverhill, Roscommon
Type of inspection:	Unannounced
Date of inspection:	27 April 2022
Centre ID:	OSV-0000384
Fieldwork ID:	MON-0033560

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Sonas Nursing Home Cloverhill is a 53 bed purpose-built facility combining care and a home environment for those no longer able to live alone. A full spectrum of individualised care is available for residents. Residents can avail of gardens, sitting rooms, TV lounge and activity room. It is situated in a rural area approximately two miles from Roscommon town. The centre's statement of purpose, states that Sonas Nursing Home offers long term care for residents with chronic illness, mental health illness including Dementia type illness and End of Life Care in conjunction with the local Palliative Care Team. The centre comprises three different care areas each with its own sitting and dining areas. There are enclosed accessible gardens available and ample parking is available.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	41

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 27 April 2022	09:30hrs to 19:45hrs	Michael Dunne	Lead
Wednesday 11 May 2022	11:25hrs to 20:25hrs	Michael Dunne	Lead
Wednesday 27 April 2022	09:30hrs to 19:45hrs	Leanne Crowe	Support
Wednesday 11 May 2022	11:25hrs to 20:25hrs	Niall Whelton	Support

What residents told us and what inspectors observed

From what residents and visitors told the inspectors, and from what the inspectors observed, residents were happy with the care that they received within the centre. Residents seemed content in the company of staff and inspectors observed many positive interactions between staff and residents on both days of the inspection. Inspectors observed a calm and relaxed atmosphere in the centre with residents in receipt of timely support from the staff team. Residents were smartly dressed and were wearing suitable clothing and footwear.

This was an unannounced inspection completed over two days. Prior to accessing the centre, inspectors were guided through the infection prevention control assessment and procedures. Inspectors met with residents, the management team,staff members and visitors over the course of the two days.

A number of staff facilitated activities during the inspection. Residents were observed to enjoy various activities, such as knitting, a game of darts and gardening. Staff were observed encouraging residents to engage in activities, and to provide reassurance where needed. While there was a vibrant atmosphere noted throughout many of the communal rooms, inspectors observed that there was much less activity occurring in one day room. Inspectors noted that focus was required in relation to this day room, to ensure that residents spending their time there were afforded the opportunity to engage in activities that met their abilities and preferences. This was also the case for those residents who sent most of their times in their bedrooms and who were found to have limited opportunities for social interactions and meaningful activities.

Residents views and opinions were accessed on a daily basis by staff and more formally in resident committee meetings. On the whole resident feedback was positive regarding the service provided. Information boards contained information about the centre including information on accessing advocacy.

Residents had access to a number of internal garden and smoking areas. Inspectors found that there were minimal environmental restraints with residents able to access most areas in the designated centre. On day one of the inspection, inspectors were informed that the registered provider was carrying out building works to the rear of the designated centre. On closer inspection it was observed that these works had impacted on the use of an existing fire exit while another fire exit in close proximity was also not in use. These findings resulted in inspectors issuing an urgent compliance plan regarding the risks identified. Inspectors were not assured that the actions identified by the provider in their compliance plan response were sufficiently robust. A second day inspection to review the arrangements the provider had in place to mitigate against the risks resulting from the decommissioning of these fire exits was carried out. The findings in relation to day two of the inspection are discussed in more detail under Regulation 28.

Visitors said that they were happy with the care provided to their loved ones and that the arrangements in place for visiting was well managed. One visitor was heard stating that "my parent is getting a new lease of life in here". Inspectors observed visitors attending the designated centre throughout both days of the inspection.

Residents were happy with the choice of food provided and said that they could have something different if they did not like what was on the menu. Residents also confirmed that they had a choice of where to have their meal, either in the dining rooms located within their own unit or they could have their meal delivered to their room.

A programme of maintenance was ongoing at the time of the inspection, which included the painting and re-flooring of several bedrooms, replacement of equipment, and the landscaping of outdoor areas. Some of these items had been completed prior to the inspection, with more planned for the coming months.

While the premises was nicely decorated, comfortable and met the majority of residents' needs, some aspects of the environment were not in a good state of repair. For example, a small hole was noted in the flooring outside a bathroom, which represented a trip hazard. Some surfaces were worn or rusted, which prevented them from being effectively cleaned. A significant number of doors and door jambs were in need of repair as they were found to be scuffed and damaged. There were however, robust cleaning arrangements in place which were monitored and reviewed by the registered provider. Additional cleaning resources had been provided by the registered provider during a recent outbreak of COVID-19.

Many residents' rooms were personalised with items of their choosing and also contained chairs, bedside lockers and wardrobes.

However, the layout of a number of twin bedroom accommodation did not facilitate residents being able to access their personal items within their own bed space and required them to have to enter other residents' private space to access their clothing and other personal items. Some twin bedroom accommodation did not contain all the furniture as identified in the regulations to be provided such as the provision of a chair and personal storage space.

Inspector's were not assured that the current layout of these twin bedded rooms could safely accommodate residents of maximum dependencies without having a negative impact on residents privacy and dignity.There was limited space available for the use of mobility equipment or transfer aids such as mobility chairs and hoists. Additionally, residents in some of these bedrooms were required to share a television, which did not consistently promote residents' choice. During the inspection, the layout and design of multi-occupancy rooms was discussed with the management team.

On the second day of inspection, inspectors walked through the building with a focus on reviewing fire precautions and were accompanied by two members of management. There had been very little progress since the first day of inspection to address the identified fire safety non-compliances.

The decommissioned exit door separated the designated centre from the adjoining construction site. There was a lit exit sign over the door which could potentially mislead staff and residents during an evacuation. Since the first day of inspection, a sign had been placed on the wall of the corridor, to direct occupants away from this exit. The library was located in close proximity to the decommissioned exit. There was an exit directly from this room but this exit was also decommissioned due to refurbishment works in this room. There was a missed opportunity to utilise this escape route as an interim measure while the construction works were ongoing.

The doors along escape routes were narrow and inspectors were not assured that they were sufficiently wide to enable evacuation of the building. Verbal assurances were given to inspectors that all evacuation aids were freely able to manoeuvre through these doors.

There were floor plans displayed and they showed the size and extent of fire compartments in the building. The floor plans had not been amended to show an altered evacuation strategy and the decommissioned exits were still showing as exits.

Inspectors noted an exit which led to a courtyard garden to the rear, escape from which was through a gate to the car park. There was a tractor and trailer associated with the construction site obstructing this escape route.

Inspectors noted gaps around the edge of a number of fire doors within the compartment boundaries. This means they would not be fully effective in preventing the uncontrolled spread of smoke and fire through the building. There were further deficiencies noted to other fire doors within the building, therefore a fire door assessment is required to ensure fire doors are effective to contain and prevent the uncontrolled spread of fire and smoke.

The boiler and electrical rooms were noted to have gaps in the ceilings which required sealing up.

Hoists were stored within a sectioned off area on a bedroom corridor. Hoist batteries left on charge in this location created a potential risk of fire and there was no risk assessment available for inspectors to review regarding this practice..

Externally, oxygen cylinders were stored in a locked cage within the refuse compound. While this areas was not up against the nursing home, inspectors noted a gas cylinder stored with the oxygen cylinders. These should be stored separately.

There were two smoking shelters for residents who wish to smoke. When inspectors pressed the call bell in both, they either didn't work or were not responded to. There was a fire blanket in place, however the date for review had expired.

Fire alarm panels were located at both the nurse station and the main entrance and they were noted to be free of fault.

The next two sections of this report will present findings of this inspection in relation to the governance and management arrangements in place and on how these

arrangements impact on the quality and safety of the service provided.

Capacity and capability

This was an unannounced risk inspection by inspectors of social services carried out to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) 2013 (as amended).

Inspectors found a number of repeated non compliance's during this inspection which had the potential to result in poor outcomes for the residents living in the designated centre. While the provider had governance structures in place they were not been used to promote effective oversight. As described in other sections of this report poor record keeping, lack of oversight regarding the training and development of staff, and systems relating to the governance and management of the centre required a number of actions to bring the designated centre into full compliance with the regulations**.**

In particular the provider had failed to identify and manage a number of risks including fire safety risks in the centre. This necessitated the inspectors returning to the designated centre for a second inspection day. The registered provider was issued with an urgent compliance plan after day one of the inspection however inspectors were not assured that the registered provider's response was sufficiently robust to reduce or eliminate the risks identified.

The second day of inspection was focused on reviewing fire precautions in the centre. Further fire safety deficits were found and as a result, inspectors were not assured that residents were adequately protected from the risk of fire. For example the fire management policy was not available to inspectors on the day of inspection and was submitted following the inspection. The fire policy was at an organisational level and did not include detail on the specific fire safety measures in Sonas Nursing Home Cloverhill, nor did it reference the altered means of escape and evacuation strategy that should have been ut into place during the course of the current construction works.

There was a risk assessment completed for the internal and external building works which were taking place however the control measures identified in the risk assessment were not being fully implemented.

Sonas Nursing Homes Management Company Limited is the registered provider for this designated centre. There was a clearly defined management structure in place that were responsible for the delivery and monitoring of effective health and social care support to the residents. The management team consisted of a person in charge who had recently been recruited to this post. They were supported in their day-to-day role by a regional quality manager and by a director of quality and governance. A team of nursing staff consisting of an assistant person in charge, a clinical nurse manager provided clinical support along with health care assistants,

household, catering and maintenance staff made up the full complement of the staff team.

Inspectors were informed that the provider had an ongoing recruitment programme in place. At the time of this inspection nurse staffing levels were consistent with the statement of purpose. A number of posts for healthcare assistants were vacant with these roles currently been filled by agency staff. The provider informed inspectors that three health care assistants were recruited to these roles and would be starting later that week.

Inspectors found that there were gaps in mandatory training and in records relating to the monitoring of training. This meant that the provider was unable to assure themselves that their staff were adequately trained to perform their role and that their mandatory training requirements had been completed.

There was a complaints policy and procedure in place which was well known among both the staff and residents. Staff confirmed that they were able to support residents register a complaint should they feel the need to do so. Complaints was an agenda item in governance meetings and it was seen that the provider was seeking to learn from complaints to improve service provided to the residents.

Regulation 14: Persons in charge

There was a full-time person in charge who had recently been appointed to this position. The person in charge met the criteria for this role as set out under regulation 14.

Judgment: Compliant

Regulation 15: Staffing

A review of the rosters and observations carried out during the inspection confirmed that there was adequate staffing in place to meet residents' assessed needs in accordance with the layout of the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

There were gaps identified in the provision of mandatory safeguarding training, inspectors identified that six staff members required updated training. Several training records were available for review however they were incomplete and could not be verified during the inspection.

Judgment: Not compliant

Regulation 21: Records

The maintenance and accessibility of records required actions to ensure that they were available and accessible for review. For example inspectors were unable to access up-to-date fire training records for staff in the designated centre. A number of training records were available on the centre's computer system for review but none gave an accurate account of fire training completed by staff working in the designated centre. In addition Inspectors found that a number of care records were not accurate as they did not describe the needs and abilities of residents. The allocation of staff and their assigned roles were not accurately reflected on the roster for multi-tasked attendants.

Judgment: Not compliant

Regulation 23: Governance and management

There were a number of actions required on behalf of the registered provider regarding their systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored. This was evidenced by:

- Poor monitoring and oversight of systems to monitor training and development of staff.
- Ineffective use of information collated to improve services for residents. An audit on infection prevention and control had been carried out by a member of the management team following the most recent outbreak of COVID-19 in the centre. While several areas of improvement were identified, a written action plan had not been developed in response to the findings.
- Poor record management.
- Poor oversight and identification of risk regarding the closure of fire exits and unsafe storage of items in cupboards.
- Poor fire safety management.

Judgment: Not compliant

Regulation 34: Complaints procedure

The registered provider had made available an accessible and effective complaints procedure which met the requirements of the regulations. All complaints were dealt with in line with the designated centres complaints policy and procedure. with complainants satisfaction recorded on all complaints received. The management team reviewed complaints received at their governance meetings in order to maintain and identify improvements in the service offered to residents.

Judgment: Compliant

Quality and safety

Overall, residents received good standards of health care and their rights and preferences were supported. However, fire safety risks related to the existing premises, storage of items in cupboards and the ongoing construction works were impacting on the safety of residents. Additionally, areas of poor practice in relation to care planning and infection prevention and control required actions to ensure positive outcomes for the residents.

On the first day of the inspection, inspectors noted that two fire exits had been temporarily decommissioned to facilitate some ongoing construction and refurbishment works. One fire exit had been decommissioned for approximately six months, while the second had been decommissioned a few weeks prior to the inspection. Inspectors were not assured that measures had been implemented to ensure that residents, in the event of an emergency, could be safely evacuated using an alternative route. A risk assessment had only been completed in relation to one of the exits. Although it set out a range of measures to mitigate the risk to residents, some of these measures had not been completed. For example, residents' personal emergency evacuation plans had not been revised, there was no evidence that fire drills had been carried out which reflected the changes to the evacuation route and fire maps not been updated. Further risks in relation to fire safety identified on the first day of the inspection included access to other fire exits being impeded by laundry skips. Fire safety compliance is discussed further under Regulation 28 of this report.

The centre was provided with a fire detection and alarm system, emergency lighting and fire fighting equipment such as fire extinguishers and fire blankets.

The most recent records available for the emergency lighting identified some lighting units which were not working and there was no documentation available to confirm if these units had been repaired. The records showed that the fire detection and alarm system was being serviced, however the system was identified as being an L2/L3 type system and not an L1 system as would be expected in a nursing

home. To this end inspectors were not assured that the coverage of the fire alarm system extended to all areas of the centre.

Residents were supported to access appropriate health care services in line with their assessed needs and preferences. General Practitioners (GP) attended the centre on a weekly basis, residents had regular medical reviews and were referred to allied health professionals if required. There was evidence of visits from allied health professionals, such as chiropodists, and their recommended interventions were recorded.

Inspectors noted that staff were working towards reducing the use of restraint in the centre. Nineteen residents were using full-length bedrails at the time of the inspection, approximately 46% of the total number of residents accommodated in the centre. These were recorded in the centre's restraint register and were subject to assessments. There was evidence that staff worked with residents to minimise the use of restraint where possible. For example, a recent trial of removing bedrails for one resident had been successful and therefore were no longer in use.

A programme of activities were in place in the centre, which was facilitated by an activity co-ordinator and other members of staff. There were appropriate facilities for activities, with a number of day rooms and other communal rooms situated throughout the centre, as well as several outdoor courtyards. Many residents had opportunities to participate in activities in accordance with their abilities and interests. However, it was noted that residents in one day room and those residents who spent a lot of time in their bedrooms had less to occupy them during the day of the inspection. This was raised with the management team at the time, who advised that it was planned to increase sensory-based activities for residents. A review of records of activities completed with residents raised concerns that these were not being accurately completed, as a number of examples were identified that did not reflect the abilities of particular residents at the time of the inspection.

Residents' rights were respected and residents were consulted with in relation to the day-to-day operation of the centre. Residents' committee meetings had recently taken place and records indicated that the ongoing building works were discussed with residents. Residents were supported to access the independent advocacy services. The centre had adequate arrangements for residents to communicate freely and had access to radio, television, newspapers and other media.

Overall, staff were found to comply with good hand hygiene and the correct use of personal protective equipment (PPE). While there was a comprehensive cleaning schedule in place for the overall premises, the schedule for the cleaning of resident equipment was completed at night and did not meet the required standards to ensure that any equipment that was used by more than one resident is cleaned and decontaminated between each use. In addition some equipment and parts of the premises required refurbishment or repair, as their current state did not promote effective cleaning or decontamination. A maintenance programme was ongoing at the time of the inspection, which the management team hoped would address many of the issues identified.

Regulation 11: Visits

Visits were seen to take place in line with updated visiting guidelines. Visitors were seen attending the centre throughout the inspection with residents and visitors satisfied with the arrangements that were in place. Staff were observed checking visitors' temperatures and guiding them through hand hygiene practices upon entry to the centre.

Judgment: Compliant

Regulation 17: Premises

While the provider had a programme of refurbishment in place, primarily to reconfigure three double occupancy rooms to single occupancy and to upgrade facilities in the library room, there were a number of items raised with the provider which included:

- Unsafe storage of items located throughout the centre. Inspectors found combustible materials stored in cupboards containing electrical and communication equipment. The registered provider removed these items when this was brought to their attention.
- Some areas of the premises required decoration, they looked dated and required refurbishment. Inspectors were informed there was a programme in place to improve facilities however records were not available to show what was going to be updated and by when.
- Two twin rooms required reconfiguration as in their current layout, they did not provide residents with access to seating and space to store their personal belongings.
- An unregistered area located on the first floor was being used to store resident records which were required to facilitate the day to day running of the designated centre.
- Some items of mobility equipment and laundry skips were being stored in residents' bathrooms.

Judgment: Not compliant

Regulation 26: Risk management

There was a risk management policy in place and a risk register was maintained however these did not include some identified risks in relation to fire safety, as set

out under Regulation 23.

Additionally, the centre's policy stated that the five specific risks required by Regulation 26, such as abuse, the unexplained absence of a resident or accidental injury to residents, visitors or staff were set out in the centre's risk register. The risk register reviewed by inspectors did not refer to any of these five risks and therefore inspectors could not be assured that appropriate controls were in place to mitigate these risks.

Judgment: Not compliant

Regulation 27: Infection control

Improvement was required to ensure compliance with the national standards. For example:

- Areas of rust were identified on some equipment.
- A hoist was being stored inappropriately in a bathroom and was found to require cleaning.
- Some wooden surfaces were chipped or the varnish had worn off in places. This meant that the surfaces were impaired and difficult to clean.
- Inspectors were not assured that shared equipment was cleaned and decontaminated between each use.

Judgment: Not compliant

Regulation 28: Fire precautions

At the time of inspection, the registered provider had not taken adequate precautions against the risk of fire, nor were fire precautions being adequately reviewed.

- Two fire exits had been decommissioned and were not in use; one from the escape corridor as a result of the construction of an extension, and the other from the library while the room was being upgraded. The control measures in the centres own risk assessment during construction were not being implemented to ensure that residents and staff were clear about the revised evacuation routes and had practised same.
- One area of the building with three bedrooms was found to present a risk of fire to residents. The attic area of these rooms contained large volumes of combustible storage and inspectors were not assured that this area was adequately fire separated from the rooms below.
- There were a number of electrical cupboards which contained combustible

storage.
- The call bells in the smoking areas, were either not working or were not responded to when pressed by inspectors.
- The door to a kitchen was held open by the door stop in the ground.

Actions and/or further assurance were required with respect to the following to ensure an adequate means of escape;

- The width of doors along corridors and through some final exits were narrow and further assurances were required that all evacuation aids in use could freely move along escape routes.
- There was a tractor associated with the construction site parked partially obstructing the escape from the garden area to the rear
  while regular checks of exits were logged, one exit was found with debris and it was evident that it hadn't been opened for a period of time.
- Curtains were positioned across exits causing a potential obstruction. Curtains or blinds should be hung in a way so as not to impede the use of the exit.

Actions were required to ensure that adequate measures were in place to contain fire and protect escape routes:

- Fire doors to some rooms and within some compartment walls required action to ensure they could effectively prevent the spread of smoke and fire.
- The fire doors to the electrical cupboards were not fitted with either heat or smoke seals. If a fire started in the electrical cupboard, the doors would not effectively prevent the spread of smoke and fire to the escape corridor they were located.
- Of the sample of doors reviewed, inspectors noted door closers to two residents' bedrooms which did not work.
- The door leading to the extension was not a fire rated door. An active construction site presents a risk of fire and the residents in the designated centre should be protected from the risk of fire occurring in, and spreading from, the construction site to the designated centre.
- The door to a cleaning press was not a fire rated door.
- There was a number of recessed fittings, attic hatches and mechanical extract units within the ceiling through out. Assurance is required that where required, the fire rating of the ceiling throughout is maintained.
- The inspectors noted gaps in the ceiling above the boiler room and electrical room which required sealing up to prevent the spread of smoke and fire.

To ensure adequate detection of fire, an additional smoke detector was required in the assisted bathroom which contained a powered whirlpool bath.

Inspectors could not establish whether all staff had received up-to-date training in fire safety. Owing to the lack of training records available, inspectors were not assured that the provider had made arrangements for staff to receive requisite training in fire prevention and emergency procedures as set out in the regulations.

The provider had not made adequate arrangements to ensure that staff were aware

of the procedure to be followed in the event of a fire. Fire drill reports available to the inspectors did not reflect the decommissioned exits, nor did they demonstrate the use of evacuation aids such as ski sheets. Fire drill reports did not contain sufficient information to demonstrate the effectiveness of the evacuation procedure.

Inspectors were not assured that adequate arrangements had been made for evacuating residents from the centre. The dependency schedule shown to inspectors included the evacuation requirements for residents both when in and out of bed. While this is good practice, there were a number of gaps where the evacuation requirements of some residents were not listed on the schedule, some of whom were identified as being maximum dependent.

While fire notices were displayed, they did not reflect the altered escape strategy.

There was a fire safety register in place. Considering the findings of this inspection with respect to fire doors, means of escape risks associated with inappropriate storage, the in-house fire safety and maintenance checks required actions to ensure they were of adequate extent, frequency and detail.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

While some care planning documentation demonstrated comprehensive knowledge of residents' individualised needs and person-centred care, this was not consistent. Inspectors identified that some assessments and care plans were not being reviewed or updated every four months as required. Furthermore, some revised care plan records contained incorrect information, or information that no longer reflected the resident's condition or assessed needs and as a result these care plans did not provide accurate and up to date information so that staff could provide care safely and in line with the resident's current needs.

For example, a resident's care plan that had been reviewed 4 times within the last 12 months continued to refer to a need for an assessment by a physiotherapist, despite this resident no longer requiring a physiotherapy assessment. Another care plan in relation to a resident's mobility referred to the use of particular equipment, despite the resident's condition rendering them unable to use such equipment for the last five months.

Judgment: Not compliant

Regulation 6: Health care

The inspectors found that residents had timely access to medical and allied health

care support to meet their assessed needs. Residents had a choice of general practitioners (GP).

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

A record of the use of restraint was maintained in the centre and assessments were in place to support the use of restraint, such as bedrails.

Judgment: Compliant

Regulation 9: Residents' rights

Not all residents were being provided with sufficient opportunities to engage in activities that were aligned to their needs and preferences. Residents in some twin bedrooms were required to share a television, which did not consistently promote residents' choice.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Sonas Nursing Home Cloverhill OSV-0000384

Inspection ID: MON-0033560

Date of inspection: 27/04/2022

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The training matrix has been comprehensively reviewed and is now up-to-date and easily retrievable. Complete.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The recently appointed PIC has now comprehensively reviewed all records. Training records are up-to-date. A plan is in place to ensure that care records will be reflective of the care needs required and provided. Staff nurse meetings have taken place and additional rostered time and mentorship has been allocated so that the nurses can review all of their records and update them accordingly. Two care plan audits will take place in July and August in order to provide further assurances. 30/08/2022. Ongoing mentorship and further education in relation to care planning is being provided. 30/09/2022. The roster now clearly identifies the MTA allocations. Complete.	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The training records had been maintained but not systematically and not inputted to the training matrix. The recently appointed PIC has rectified this. The training matrix will continue to be an item for discussion at the monthly governance meetings. Complete.
Meetings and mentorship for nursing staff are ongoing. Additional time has been rostered to enable the nursing team to fully upskill themselves with the care recording requirements. 30/09/2022.

The incomplete infection control audit had been conducted by the provider as an assurance audit and was not part of the operational plan. All audits on the operational plan have adhered to the quality improvement cycle. The findings from the provider audit were actioned on the dsay of audit and/or brought forward to the Emergency Governance Meeting and the action plan agreed from there. Complete.

Now that the new mangement team is settled all records have been comprehensively reviewed and updated if required. All records can now be easily retrieved. Complete.

Additional Fire related risk assessments have been completed. Complete.

The providers plan to address the fire safety issues raised is addressed under regulation 28.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A programme of refurbishment is in place, primarily to reconfigure three double occupancy rooms to single occupancy and to upgrade facilities in the library room, there are a number of other items that have been or will be addessed to included:

• Unsafe storage of items located throughout the centre. Inspectors found combustible materials stored in cupboards containing electrical and communication equipment. The registered provider removed these items when this was brought to their attention. Complete.
• Some areas of the premises required decoration, they looked dated and required refurbishment. Inspectors were informed there was a programme in place to improve facilities however records were not available to show what was going to be updated and by when. An ongoing maintenance programme is in place which includes redecoration of the centre and replacement of furniture and equipment where required. Complete and ongoing.
• Two twin rooms required reconfiguration as in their current layout, they did not provide residents with access to seating and space to store their personal belongings. These rooms are being reconfigured with revised dividing curtain layout and furniture upgraded to provide individual personal space and access to seating and storage for personal

belongings. 30/08/2022
• An unregistered area located on the first floor was being used to store resident records which were required to facilitate the day to day running of the designated centre. An aplication to register this area has been submitted to the Chief Inspector.
• Some items of mobility equipment and laundry skips were being stored in residents' bathrooms. These items have been removed from these rooms. Complete.
• Inspector's were not assured that the current layout of these twin bedded rooms could safely accommodate residents of maximum dependencies without having a negative impact on residents privacy and dignity.There was limited space available for the use of mobility equipment or transfer aids such as mobility chairs and hoists. The layout of these rooms are being reconfigured. No resident requiring mobility or transfer aids will be admitted to these rooms. 30/08/2022.
• Additionally, residents in some of these bedrooms were required to share a television, which did not consistently promote residents' choice. This will be reviewed with each resident as part of their care plan. Their choice will be facilitated. Ongoing

Regulation 26: Risk management	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
We accept that the inspectors identified additional risks on the days of inspection. Those which could be readily responded to were addressed immediately.

"Additionally, the centre's policy stated that the five specific risks required by Regulation 26, such as abuse, the unexplained absence of a resident or accidental injury to residents, visitors or staff were set out in the centre's risk register. The risk register reviewed by inspectors did not refer to any of these five risks and therefore inspectors could not be assured that appropriate controls were in place to mitigate these risks". All of these risks are comprehensively recorded in the centres risk management dataase – this database was not reviewed during the inspection. Ongoing

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
All equipment has been cleaned and any items with rust have been removed.
A comprehensive maintenance plan is in place which will address the wooden areas which need repair and/or varnishing. Ongoing

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: A professional with expertise in fire regulations has completed the premliminary inspection of the centre and will complete a fire risk assessment and action plan by 31/07/2022. The fire risk assessment and plan of action will be submitted to the Chief Inspector. A letter of engagement with the Fire Consultant is being submitted with this compliance plan.

A number of the non-compliance have already been addessed as folows:

• Two fire exits had been decommissioned and were not in use; one from the escape corridor as a result of the construction of an extension, and the other from the library while the room was being upgraded. The control measures in the centres own risk assessment during construction were not being implemented to ensure that residents and staff were clear about the revised evacuation routes and had practised same. Both fire exits are now in use. Complete.
• One area of the building with three bedrooms was found to present a risk of fire to residents. The attic area of these rooms contained large volumes of combustible storage and inspectors were not assured that this area was adequately fire separated from the rooms below. The attic area in no longer in use for storage. Complete.
• There were a number of electrical cupboards which contained combustible storage. Combustable material has been removed. Complete.
• The call bells in the smoking areas, were either not working or were not responded to when pressed by inspectors. There was a fire blanket in place, however the date for review had expired. Fault in call bell has been rectified and fire blanket with current review date in place. Complete.
• The door to a kitchen was held open by the door stop in the ground. Door stop removed. Complete.
• The decommissioned exit door separated the designated centre from the adjoining construction site. There was a lit exit sign over the door which could potentially mislead staff and residents during an evacuation. Since the first day of inspection, a sign had been placed on the wall of the corridor, to direct occupants away from this exit. The library was located in close proximity to the decommissioned exit. There was an exit directly from this room but this exit was also decommissioned due to refurbishment works in this room. The original escape routes are now back in use. Complete.
• The doors along escape routes were narrow and inspectors were not assured that they were sufficiently wide to enable evacuation of the building. Written assurances and video evidence submitted with compliance plan to the Chief Inspector which confirm that evacuation aids were freely able to manoeuvre through these doors. Regular drils with all staff will be ongoing. Completed and ongoing.
• There were floor plans displayed and they showed the size and extent of fire compartments in the building. The floor plans had not been amended to show and altered evacuation strategy and the decommissioned exits were still showing as exits.

The floor plans on display show the current evacuation routes. Complete.
• Inspectors noted an exit which led to a courtyard garden to the rear, escape from which was through a gate to the car park. There was a tractor and trailer associated with the construction site obstructing this escape route. The route is clear of obstruction and checks are in place to ensure that this and all exits are clear of debris and can be opened. Complete and ongoing.
• Inspectors noted gaps around the edge of a number of fire doors within the compartment boundaries. This means they would not be fully effective in preventing the uncontrolled spread of smoke and fire through the building. There were further deficiencies noted to other fire doors within the building, therefore a fire door assessment is required to ensure fire doors are effective to contain and prevent the uncontrolled spread of fire and smoke. Actions were required to ensure that adequate measures were in place to contain fire and protect escape routes. A fire door assesment has been completed, replacement and remedial work has commenced and will be completed by 01/11/2022.
• The door leading to the extension was not a fire rated door. An active construction site presents a risk of fire and the residents in the designated centre should be protected from the risk of fire occurring in, and spreading from, the construction site to the designated centre. A one hour fire rate door will be fitted at this location as specified in Fire Drawings for extension. 01/08/2022.
• There was a number of recessed fittings, attic hatches and mechanical extract units within the ceiling through out. Assurance is required that where required, the fire rating of the ceiling throughout is maintained. This will be addrssed in fire risk assessment and action plan completed by competent person in fire regulations.
• The boiler and electrical rooms were noted to have gaps in the ceilings which required sealing up. Gaps addressed. Complete.
• Hoists were stored within a sectioned off area on a bedroom corridor. Hoist batteries left on charge in this location created a potential risk of fire and there was no risk assessment available for inspectors to review regarding this practice. A risk assessment has been completed of hoist store and charging area. Complete and ongoing.
• Externally, oxygen cylinders were stored in a locked cage within the refuse compound. While this areas was not up against the nursing home, inspectors noted a gas cylinder stored with the oxygen cylinders. These should be stored separately. Gas cylinder has been removed. Complete.
• Curtains were positioned across exits causing a potential obstruction. Curtains or blinds should be hung in a way so as not to impede the use of the exit. This potential obstruction has been addressed. Complete.
• To ensure adequate detection of fire, an additional smoke detector was required in the assisted bathroom which contained a powered whirlpool bath. Smoke detector will be fitted by 14/07/2022.
• Inspectors could not establish whether all staff had received up-to-date training in fire safety. Owing to the lack of training records available, inspectors were not assured that the provider had made arrangements for staff to receive requisite training in fire prevention and emergency procedures as set out in the regulations. All staff have received up-to-date training and are aware of responses to emergency procedures. Training records are available with record of training completed by staff. Complete.
• The provider had not made adequate arrangements to ensure that staff were aware of the procedure to be followed in the event of a fire. Fire drill reports available to the inspectors did not reflect the decommissioned exits, nor did they demonstrate the use of

evacuation aids such as ski sheets. Fire drill reports did not contain sufficient information to demonstrate the effectiveness of the evacuation procedure. Fire drills have been reviewed and implemented to demonstrate the effectiveness of the evacuation procedure. All Fire Drills are recorded. Complete and Ongoing.
• Inspectors were not assured that adequate arrangements had been made for evacuating residents from the centre. The dependency schedule shown to inspectors included the evacuation requirements for residents both when in and out of bed. While this is good practice, there were a number of gaps where the evacuation requirements of some residents were not listed on the schedule, some of whom were identified as being maximum dependent. All residents have a current PEEP which is reviewed on a regular basis. Complete and ongoing.
• While fire notices were displayed, they did not reflect the altered escape strategy. Fire action plan has been reviewed which reflects evacuation routes in place. Complete.
• There was a fire safety register in place. Considering the findings of this inspection with respect to fire doors, means of escape risks associated with inappropriate storage, the in-house fire safety and maintenance checks required actions to ensure they were of adequate extent, frequency and detail. Fire safety and environmental checks have been reviewed and deficits regarding details of extent, frequency and detail included. Complete and ongoing.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
A full review of all residents assessments and care plans has now taken place. Complete.

A plan is in place to ensure that care records will be reflective of the care needs required and provided. Staff nurse meetings have taken place and additional rostered time and mentorship has been allocated so that the nurses can review all of their records and update them accordingly. Two care plan audits will take place in July and August in order to provide further assurances. 30/08/2022. Ongoing mentorship and further education in relation to care planning is being provided. 30/09/2022.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
As we return to pre-Covid-19 control measures we are reviewing the use of our day rooms and the activities provided in all. Discussions have taken place with the activities

team and a resident survey has been conducted. A plan is in place to ensure that each resident can avail of a social, recreational and therapeutic activities of their choice. Staff allocations are also under review. 31/07/2022.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	19/07/2022
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	30/08/2022
Regulation 21(1)	The registered provider shall 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.	Not Compliant	Orange	19/07/2022
Regulation 23(c)	The registered provider shall ensure that management	Not Compliant	Orange	19/07/2022

	systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.	Not Compliant	Orange	19/07/2022
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.	Not Compliant	Orange	19/07/2022
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.	Not Compliant	Orange	19/07/2022
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy set out in Schedule 5	Not Compliant	Orange	19/07/2022

	includes the measures and actions in place to control aggression and violence.			
Regulation 26(1)(c)(v)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.	Not Compliant	Orange	19/07/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	30/08/2022
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	19/07/2022
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency	Not Compliant	Orange	19/07/2022

	lighting.			
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	19/07/2022
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Red	01/11/2022
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Not Compliant	Red	02/05/2022
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at	Not Compliant	Red	02/05/2022

	suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	01/11/2022
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	19/07/2022
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Not Compliant	Orange	19/07/2022
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph	Not Compliant	Orange	30/09/2022

	(3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	31/07/2022
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	31/07/2022