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 Ard Na Greine
Name of provider:	Sonas Asset Holdings Limited
Address of centre:	Bothar na Cé, Enniscrone, Sligo
Type of inspection:	Unannounced
Date of inspection:	11 October 2022
Centre ID:	OSV-0005421
Fieldwork ID:	MON-0037588

About the designated centre

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

Sonas Ard na Gréine is a purpose built nursing home providing 24-hour long term, convalescent and respite care for both male and female residents. The centre is situated in the town of Enniscrone, Co. Sligo. The aim of the home is to provide a residential setting wherein residents are cared for, supported and valued within the care environment that promotes the health and well being of residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	49

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
Tuesday 11 October 2022	09:15hrs to 18:00hrs	Michael Dunne	Lead
Tuesday 11 October 2022	09:15hrs to 18:00hrs	Rachel Seoighthe	Support

What residents told us and what inspectors observed

Overall, inspectors found that residents were content living in the centre and that they were satisfied with the care and service provided. General feedback from residents was positive regarding their quality of life and the levels of support that they received. Residents told inspectors that they felt safe in the centre, were well cared for and that their meals were of a good standard. The inspector observed that residents were comfortable in the company of staff and that staff were attentive to the residents' needs for assistance and support. Staff interactions with residents were observed to be caring, gentle and respectful.

Sonas Ard na Gréine is a purpose built two storey nursing home providing long term and respite care for both male and female residents. The centre is located on the outskirts of Enniscrone town, Co. Sligo. Residents' accommodation was provided in twin and single occupancy bedrooms located on the ground floor. The inspectors saw that some bedrooms were personalised, with items such as family pictures and soft furnishings. Residents told the inspectors that they were happy with their rooms and they found they were comfortable and were cleaned on a regular basis.

There are a variety of communal areas for residents to use on the ground floor consisting of two sitting rooms, a conservatory and an oratory. Inspectors observed that the sitting rooms were bright and spacious and were well used by residents throughout the day of the inspection.

The corridors in the centre were long and wide and provided adequate space for walking. Inspectors observed that walls were decorated with brightly coloured artwork. Handrails were in place on both sides of all corridors to enable residents mobilise in a safe manner. A toilet and en-suite facility was found to have been reassigned as a visitors toilet.

There are two secure enclosed garden areas in this centre which had sufficient seating in place to meet the needs of the residents. Inspectors observed that these areas were well maintained and contained shrubs and flowers and sufficient seating to support residents' comfort. However, access to one of these area's was restricted as when the door to the garden was opened an alarm was sounded and staff were then required to attend and monitor the door.

Inspectors attended a resident meal service where residents were observed to be in receipt of appropriate and timely support to enjoy their meal. Residents who required assistance with their eating and drinking were supported in a dignified manner by the staff supervising the meal service. Residents were provided with a choice of main meal and could also access alternative food should they not like what was on the menu. Inspectors observed that there was a selection of snacks and refreshments available for residents throughout the day. Daily menus were displayed throughout the centre, however Inspectors observed that the menus were

not in an accessible format for all residents.

Residents' were seen to receive visitors throughout the day and all were observed to adhere to infection prevention and control protocols which included the wearing of a face mask and hand hygiene. Potential visitors were required to contact the centre in advance of their visit to avoid large footfall in the centre. Visits were available seven days a week.

Inspectors observed that staff wore face masks when providing direct care to residents. Alcohol hand gel dispensers were readily available along corridors for staff use. Staff were observed to perform hand hygiene appropriately.

The next two sections of the report describe the provider's levels of compliance with the Health Act 2007 and the Care and Welfare Regulations 2013. The findings in relation to compliance with the regulations are set out under each section.

Capacity and capability

This was an unannounced risk inspection carried out by inspectors of social services to follow up on actions taken by the registered provider since the last inspection in November 2021. In addition, inspectors assessed the registered providers compliance under a number of regulations relating to the themes of quality and safety and capacity and capability.

Inspector's found that there were actions required across a number of regulations in order for the registered provider to achieve compliance with the regulations and to ensure that the service provided was safe and effectively monitored.

Areas that needed actions included the appointment of a person in charge to manage the service and to ensure that services provided were appropriate to meet the assessed needs of the residents. While the registered provider had established systems in place to monitor the service, inspectors found gaps in the oversight of these services which included,

- Poor identification and management of risk in relation to fire safety.
- Insufficient allocation of management hours to adequately monitor the care and services provided.
- Unavailability of risk assessment records on the day of the inspection.
- Robust management of medicine practices, protection of residents and care planning. These findings are set out under the relevant regulations.

The registered provider for this designated centre is Sonas Asset Holdings Limited. There was no person in charge in place at the time of the inspection. The registered provider had submitted a plan to appoint a suitable person in charge who met the requirements of the regulations by mid November 2022. At the time of this inspection the management team consisted of a director of the company who was

supported by a quality and governance coordinator. The director of the company was based in the designated centre on day-to-day basis.

The remainder of the staff team consisted of two clinical nurse managers (CNM), a team of staff nurses, health care assistants, household, catering, maintenance and administration staff. Inspectors found that the CNMs were working 60% of their time as a nurse on duty and as a result their protected management hours were not sufficient to oversee the quality and safety of care for the residents.

At the time of the inspection there were a number of staff vacancies and the registered provider was in the process of recruiting four health care assistants, an activity coordinator, a part-time physiotherapist, a housekeeper and one catering staff.

A number of documents relating to the oversight of the service were not available for inspectors to review on the day of the inspection. For example the provider was required to submit records relating to the management of risk to inspectors post inspection. In addition the records for the recruitment of a second clinical nurse manager were not available and as such inspectors were not assured that this appointment had been secured.

The designated centre had received one complaint in 2022. A review of complaints records confirmed that the registered provider processed complaint's in accordance with the complaints policy. Inspector's found that the complaints policy was located in the lobby area near to the entrance to the centre but it was not accessible to residents.

Regulation 14: Persons in charge

- At the time of this inspection the provider did not have a person in charge in place who met the requirements of the regulations.

Judgment: Not compliant

Regulation 15: Staffing

There were not sufficient staff with the right knowledge and skills having regard to the needs of the residents. This was evidenced by;

A review of staffing rosters found that the registered provider had not ensured that the numbers of staff available in the centre were in line with the centre's statement of purpose.

The registered provider acknowledged in their governance meetings that there was

a requirement for staffing to stabilise to ensure consistency of service provided to the residents.

Inspectors found that staff nurse absences including sickness and annual leave were being covered by the clinical nurse managers which impacted on their ability to monitor care and services effectively.

In addition recruitment processes did not assure inspectors that suitable staff were appointed. For example:

- Recruitment records were not available for clinical staff who had been recently recruited to CNM post.
- One staff member had been recruited and added to the weekly roster without having a valid Garda vetting clearance in place. The member of staff was removed from the roster and did not work in the centre until their Garda Vetting was available.

Both these findings are discussed in more details under Regulation 8 Protection.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A review of training records found that all staff had completed their mandatory training which included fire safety, moving and handling, and safeguarding training. Training records were well maintained and easy to follow.

Staff had access to other training commensurate to their role and included dementia, medication management, cardio pulmonary resuscitation (CPR) and dementia training.

Judgment: Compliant

Regulation 19: Directory of residents

A review of the directory of residents found that the information specified in paragraph (3) of Schedule 3 was not entered into the directory for three residents who had been admitted to the centre.

Judgment: Not compliant

Regulation 22: Insurance

The registered provider had a contract of insurance in place against injury to residents. The insurance contract was renewed in March 2022.

Judgment: Compliant

Regulation 23: Governance and management

The management structure in the designated centre was unclear. On the day of the inspection there was no person in charge in the designated centre. The senior manager was a director of the provider entity and they were supported in their role by a clinical nurse manager. A senior staff nurse had been recently appointed to a clinical nurse manager role but there was no evidence that they had commenced in the post. The absence of a person in charge with the appropriate knowledge and experience was impacting on the quality and safety of care and services as evidenced in the findings of this inspection.

The provider had failed to ensure that there were adequate numbers of staff with the right knowledge and skills to meet the needs of the residents. This was further compounded by the lack of a clear recruitment procedure to ensure that appropriate staff were recruited to vacant roles.

The poor oversight and management or records in the centre meant that a high number of Schedule 2, 3 and 4 records and documents were not available or were not up to date when requested by the inspectors. This is addressed under Regulation 21.

The oversight and governance and management systems did not ensure that the service provided was safe, appropriate and consistently monitored. This was evidenced by the lack of a comprehensive quality assurance system to identify areas of the service that required improvement. As a result this inspection found significant disimprovement in compliance in the centre.

Risk were not identified and managed effectively. This was evidenced by;

- The risk register submitted post inspection did not identify risks that were found on inspection.
- The inspectors found management of medicines and pharmaceutical services required a number of actions to ensure that this service was safe and effectively monitored.
- Fire safety risks were not managed. For example managers and staff had not identified that a smoke alarm had been covered over. In addition gaps and breaks in fire stopping in a number of areas had not been identified and addressed. These findings are addressed under Regulation 28.

- A member of staff had been appointed without an appropriate Garda Vetting in place. This is addressed under Regulation 8.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had a statement of purpose in place which included the information set out in Schedule 1 of the regulations. However this document had not been updated to reflect a number of changes in the centre including;

- Changes to the management structure within the designated centre or accurately.
- Changes to the whole time equivalent of staff working in the designated centre
- Changes in the floor plan to reflect the removal of a resident shower/toilet facility to create a visitor toilet.
- The addition of a new pod structure to the outside of the building to facilitate visiting during the COVID-19 pandemic.

Judgment: Not compliant

Regulation 34: Complaints procedure

The registered provider maintained a complaint's policy and procedure, however this was displayed in a lobby area and was difficult for residents and their families to access and read.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The policies and procedures required under schedule 5 were available in the designated centre and met the requirements of this regulation.

Judgment: Compliant

Regulation 21: Records

The registered provider failed to ensure that records set out under Schedules 2, 3 and 5 were made available for the inspector to review on the day of the inspection. A number of records were submitted post inspection which included:

- Fall Audits
- Risk assessment
- Cleaning schedules
- Infection Prevention and Control action plan review
- Garda vetting disclosure confirmation
- Certificate of Building Compliance

Judgment: Not compliant

Quality and safety

Overall, the quality and safety of care provided to residents were found to be satisfactory. Residents reported that they felt safe and well cared for. However, inspectors found that increased oversight was required to ensure that the quality and safety of care being delivered to residents was consistently managed, to ensure the best possible outcome for residents. In particular, actions were needed to bring Regulation 28 Fire Safety, Regulation 8 Protection, Regulation 27 Infection Prevention and Control, Regulation 5 Assessment and Care Planning and Regulation 9 Residents' Rights into full compliance.

Residents had access to appropriate health and medical care services. There was a general practitioner (GP) available to residents. Furthermore, residents were supported by a team of allied health care professionals including a dietitian, physiotherapist, optician and an occupational therapist. A community palliative care and a psychiatry of later life team also formed part of the multi-disciplinary support for residents. The recommendations made by the allied health care professionals were incorporated into the residents care plans.

Resident care records were maintained on an electronic nursing documentation system. Inspectors found that assessment and care planning required improvement to ensure each resident's health and social care needs were identified and the care interventions that staff must complete were clearly described. The inspectors reviewed a sample of residents' care documentation and found that some pre-admission assessments did not contain sufficient information and therefore there was a risk that some of the residents care needs would not be identified. Additionally, there were some inconsistencies in the care planning documentation as outlined under Regulation 5: Individualised assessment and care plan.

Inspectors observed that some residents expressed responsive behaviours (how people with dementia or other conditions may communicate or express their

physical discomfort). Appropriate assessments and care plans were in place to promote positive supports for residents with responsive behaviours.

There were measures in place to protect residents against the risk of fire. These included regular checks of means of escape to ensure they were not obstructed and checks to ensure that equipment was accessible and functioning. However, inspectors found that supervision of staff and oversight of fire safety risk was not robust. Inspectors observed that a smoke detector located in a communal dining room had been covered to prevent it from functioning, this practice prevented the automatic detection of smoke and the activation of the fire alarm.

This did not ensure resident safety in the event of a fire emergency in the centre and is discussed further under Regulation 23 , Governance and Management and Regulation 28, Fire precautions. The obstruction to the smoke detector was removed immediately by the registered provider when inspectors identified this risk.

Overall, the premises was clean and well maintained. The inspectors observed that there were good infection prevention and control practices and procedures in place. However, some areas required improvements which are detailed under Regulation 27. The registered provider had recently changed a resident en suite facility to a visitors toilet facility,this change meant the number of available facilities for residents to use had reduced. However the registered provider agreed to ensure that this facility reverted to its original function as a resident toilet and shower following the inspection.

Resident feedback was obtained at meetings which were convened regularly. Residents were supported to continue to practice their religious faiths and had access to newspapers, radios and televisions. Visiting was facilitated and observed to be managed in line with the national guidelines.

The provider did have processes in place to protect residents however improvement was required to ensure the protection and safeguarding of all residents in the centre. This is discussed further under Regulation 8, Protection.

Regulation 12: Personal possessions

There were systems in place to ensure residents had access to and could retain control over their personal property and possessions. Residents had lockable storage in their bedrooms. There was adequate space to store clothing and personal possessions. There were adequate laundry facilities with systems in place to ensure that residents' own clothing was returned to them.

Judgment: Compliant

Regulation 17: Premises

The premises was suitable in size and layout for the number of residents and their assessed needs. There was sufficient communal spaces available for residents to use and on the whole the centre was well-maintained, there were however concerns with regard to

- A residents shower and toilet facility being re-purposed as a visitor's toilet.
- Poor access for staff to store facilities due to location of keys.

Judgment: Substantially compliant

Regulation 26: Risk management

There was a risk management policy and procedure in place which contained details regarding the identification of risk, the assessment of risk and the measures and controls in place to mitigate against known risks.

Records associated with clinical, operational and environmental risks were not available for inspectors to review at the time of the inspection. The provider did submit a copy of their risk register to inspectors post inspection. The register did not provide the required level of assurances to indicate that risks were monitored effectively in the designated centre.This is addressed under Regulation 23.

Judgment: Compliant

Regulation 27: Infection control

The provider did not ensure that procedures consistent with the standards for the prevention and control of healthcare associated infections- published by the Authority were implemented by staff. This was evidenced by:

- A number of urinal bottles were being stored on the floor and window sill of a communal bathroom which posed a risk of cross contamination
- Storage of unused clinical waste bags in the equipment drying rack in the sluice room which posed a risk of cross contamination
- Open-but-unused portions of wound dressings were observed in the nurses station. Reuse of 'single-use only' dressings is not recommended due to risk of contamination.
- Some clinical hand wash sinks did not comply with current recommended specifications for clinical hand hygiene sinks for example, the sink in the

sluice room and laundry room.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had failed to put effective measures in place to identify and address fire safety risks in the designated centre. As a result the inspectors found the following risks that had not been identified and addressed. This was evidenced by:

- A smoke alarm sensor was covered with a glove. This was removed when inspectors alerted the provider.
- Pipes entering a ceiling area of a store room which prevented effective fire stopping in the room and creating a risk that fire and smoke could spread to other areas of the building.
- There were gaps in the ceiling tiles in the dining room which prevented effective fire stopping creating the risk that fire and smoke could spread to other areas.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors were not assured that medication practices were in line with the safe administration of medicines professional guidance, for example:

- Controlled drugs were not consistently administered in line with best practice professional guidelines. The practice of double checking controlled drugs at the start of each shift and prior to administration, was not always adhered to. This was evidenced by lack of a second signature in a number of entries into the controlled drug records.
- Medicinal products such as eye-drops and suppositories, which were out of date, were not segregated from other medicinal products which were in use.
- Residents' medicine were not stored securely in the centre and inspectors observed that medication refrigerators were unlocked in unsecured nurses stations on several occasions throughout the inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Assessment and care planning required improvement to ensure each resident's health and social care needs were identified and the care interventions that staff must complete were clearly described. The inspectors reviewed a sample of residents' care documentation and found the following;

- Not all residents had a comprehensive assessment of their needs prior to admission therefore there was a risk that some of their care needs would not be identified.
- A number of care plans had not been reviewed at 4 monthly intervals, as required under Regulation 5.

A number of plans did not contain the necessary information to guide care delivery;

- One care plan contained information which was out of date and not relevant to the resident's current condition.
- The information in some residents' care plans needed improvement to ensure it reflected each resident's individual preferences; two nutritional care plans did not state the residents food and drink preferences.
- Two care plans for a resident with a communication deficit contained conflicting information regarding the residents communication needs.

Judgment: Substantially compliant

Regulation 6: Health care

The general practitioner (GP) attended the centre weekly or more often if residents required review. Residents also had timely access to allied health services and specialist input from the psychiatry of old age, a geriatrician and the palliative care team as and when required.

Judgment: Compliant

Regulation 8: Protection

The inspector reviewed a sample of personnel files for staff and found that one staff member did not have a valid Garda Vetting disclosure in place, prior to commencing employment in the centre.

A review of the investigation in relation to a safeguarding incident found that a vulnerable resident did not have a safeguarding plan in place.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents had restricted access to an enclosed courtyard. Access to the outside space was restricted by alarm sensors to alert the staff that the door was opened. Some residents had access to the door code, however an alarm sounded each time the door was opened and staff were required to deactivate the alarm sensors manually. This system had the potential of limiting the residents choice to go outside independently. A review of this system was required to facilitate residents choice and independence.

The daily meal menu and activities schedules were not presented in an accessible format for all residents.

There was information available in the centre which gave details about independent advocacy service however this information was not clearly displayed and not easy for residents to access. As a result inspectors were not assured that all residents who may need advocacy would know how to access the service.

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	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Regulation 21: Records	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Sonas Nursing Home Ard Na Greine OSV-0005421

Inspection ID: MON-0037588

Date of inspection: 11/10/2022

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: A Person in Charge has been appointed. This Person in Charge meets the criteria set out in the regulations. This person in Charge has worked previously as a Person in Charge with Sonas Nursing homes. 16/01/2022.	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The Centre's staffing levels align with the statement of purpose. Complete and ongoing. • An additional CNM 1 was appointed and commenced in the role on 05/12/2022. Complete. • Two additional staff nurses also commenced employment on 25/10/2022. This will ensure that protected management time for CNM 1 and CNM 2 can be rostered. Complete. • There are sufficient staff nurses employed to cover annual leave and staff absence. Complete and ongoing. • All recruitment records, including garda vetting, are saved in the staff members files and all of these are now up-to-date. Complete.	

Regulation 19: Directory of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 19: Directory of residents:
• All residents details outlined in schedule 3 are included in in resident's directory. Complete.
• Prior to resident admission all residents details are entered into the directory as part of the preadmission assessment. The PIC will monitor this weekly. Complete & ongoing.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The Centre's staffing levels align with the statement of purpose. Complete and ongoing.
• The Director of Operations will step out of the role of Person in Charge due to the position now being filled. 16/01/2022.
• An additional CNM1 with six years of experience in the care of the older person and who also holds a managerial qualification had been appointed and commenced in the role on the 05/12/2022. Both CNMs can deputise in the absence of the PIC. The Director of Quality & Governance will support the team with their development in to their roles and responsibilities.
• Staff Nurse has been promoted to Senior Staff Nurse with specific responsibilities.
• Two additional staff nurses also commenced employment. This will ensure that protected management time for CNM 1 and CNM 2 can be rostered. Complete and ongoing.
• There are sufficient staff nurses employed to cover annual leave and staff absence. Complete and ongoing.
• All recruitment records, including garda vetting, are saved in the staff members files and all of these are now up-to-date. Complete and ongoing.
• The risk register has been updated to all identified risks. Further training for the new management team will be incorporated into their team development. The Director of Quality & Governance will supoort with this. Complete & ongoing.
• All nursing staff have completed medication management training to ensure they are up-to-date with best practices and guidelines. Complete.
• A new CPD programme for all nursing staff was launched in Sonas in October. As part of this all nurses must complete a Medication Competency Assessment. Complete & ongoing.
• Weekly review of medication trolleys, fridges and medication storage has been implemented to ensure that medication is appropriately managed. The management team will also monitor this on their daily walkarounds. Nursing staff have been reminded of the principles of safe medication management and their responsibilities re. same. Complete & ongoing.

• Visual inspections of heat sensors and smoke alarms are now included in the Nurse in Charge fire checks. Weekly checks by the Fire Warden now include inspection of heat sensors and smoke alarms. A member of the management team has been delegated overall responsibility for fire safety.Complete and on-going.
• All staff have been alerted to the importance of reporting heat sensor or smoke alarm faults. Complete and on-going.
• The building has no gaps or breaks in fire stopping that could pose a fire risk. Discussions have taken place at recent staff huddles and drills about not blocking any fire sensors or interfering with any fire prevention aids or equipment. Complete & ongoing.
• All staff will have a current Garda Vetting before they commence employment. The PIC will oversee this. Complete & ongoing

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• 1 x PIC, 1 x CNM 1 and 2 x staff nurses have been appointed. 16/01/2022.
• The whole time equivalent of staff working in the designated centre is now accurately reflected in the Statement of Purpose.
• The resident shower/toilet facility has now reverted to its original purpose as outlined in the floor plan Complete and ongoing.
• The pod structure to the outside of the building to facilitate visiting during the COVID-19 pandemic will be added to the floor plan 13/01/2023.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Feedback posters and the complaints procedure are now displayed in all sitting rooms. Complete and ongoing.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:

• The number of falls are monitored by the Director of Quality & Governance in the weekly PIC report and in the clinical KPIs. Root cause analysis is performed whereby an issue or concern is identified. Falls are formally analysed quarterly and action plans developed from same. Ongoing.
• A comprehensive review of risks has been undertaken and any new risks added to the risk register. All staff are being further educated about identifying and reporting hazards and risks. The Director of Quality & Governance is supporting with this. Ongoing.
• Cleaning schedules are completed daily by the Household staff and retained for inspection Completed and ongoing
• PIC will ensure that detailed actions required due to non-compliances identified in IPC audits and daily checks are completed. Completed and ongoing.
• PIC will ensure that every staff member who commences employment will have an up-to-date Garda vetting disclosure confirmation which will be available for inspection. Completed and ongoing.
• A copy of the Certificate of Building Compliance is on file in the Home and is easily retrievable. Complete.
• The management team will now develop a system so that they can easily retrieve all regulatory documents. 20/02/2023

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Resident shower/toilet that was changed has now reverted to its original intended purpose as outlined in the floor plan Complete.
• All staff now have easy access to all storage facilities. Complete.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Urinal Bottles and similar items are stored on a drainage rack in the sluice room which the nurse in charge will monitor as part of IPC daily checks. Complete and ongoing.
• Supplies of clinical waste bags are now stored in the clinical store. The the nurse in charge will monitor as part of IPC daily checks. Complete and ongoing.
• Single-use only dressings are used for individual residents only and the unused part of the dressing is disposed of as per the waste management policy. Compliance is monitored as part of the Daily IPC checks.Completed and ongoing.
• Clinical hand wash sinks in sluice room and laundry which comply with current recommended specifications for clinical hand hygiene sinks have been factored into next

years Capex budget. In the interim, we have added it to the risk register.
• Mentorship on IPC auditing will be completed for all members of the management team. The Director of Quality & Governance will support with this. 01/02/2023.
• The findings and learnings from the inspection have been discussed at the staff meetings. Complete.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• All staff have been informed of the importance of having the smoke alarm sensors uncovered at all times Complete and ongoing.
• Heat sensors and smoke alarms and visual inspections are now included in the Nurse in Charge fire checks. Weekly checks by the Fire Warden now include inspection of heat sensors and smoke alarms. A member of the management team has been delegated overall responsibility for fire safety .Complete and ongoing
• The building has no gaps or breaks in fire stopping, which could pose a fire risk. Discussions have taken place at recent staff huddles and drills about not blocking any fire sensors or interfering with any fire prevention aids or equipment. Complete & ongoing.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• All nursing staff have completed medication management training to ensure they are up-to-date with best practices and guidelines. Complete and ongoing.
• A new CPD programme for all nursing staff was launched in Sonas in October. As part of this all nurses must complete a Medication Competency Assessment. Complete & ongoing.
• Controlled drugs are checked at the change of shift. Daily supervision by members of the management team will ensure compliance Completed and ongoing.
• Weekly review of medication trolleys, fridges and medication storage has been implemented to ensure that medication is appropriately managed. The management team will also monitor this on their daily walkarounds. Nursing staff have been reminded of the principles of safe medication management and their responsibilities re. same. Complete & ongoing.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
• All residents have a comprehensive assessment of their needs completed prior to admission. All nurses received training in same. There is a new audit schedule for 2023 which will assist in ensuring that care plans and assessments are kepy up-to-date. Ongoing.
• All care plans have been reviewed in the last four months. A new operational plan for 2023 will require care plan reviews daily. This will ensure that deficits in care planning do not occur and that any gaps identified are corrected immediately. The PIC will have to report the findings to the Director of Quality & Governance in the weekly report. Ongoing.
• A Senior Staff Nurse has been allocated responsibility for Nutritional care planning. All resident's nutritional care plans are up to date. Complete and ongoing.
• The Sonas nursing homes Nurse CPD programme for all RNs, which includes comprehensive mentoring in relation to care planning, has commenced and it is anticipated that this will result in improved care planning practices.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• PIC will ensure that every staff member who commences employment will have an up-to-date Garda vetting disclosure confirmation. Complete and ongoing.
• All residents who require Safeguarding have a plan in place. Complete and ongoing.
• Nursing staff will receive further guidance on safeguarding care planning. 01/02/23.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Opening doors using code to internal courtyards will not activate the door alarm. Complete and ongoing.
• The daily menu is in a suitable format, making it accessible to all residents. Complete and ongoing.
• The activities schedule has been reviewed and is now in an accessible format to all

residents. Each resident is offered a choice of social, therapeutic and purposeful activities to meet their needs and preferences.Complete and ongoing.
• Advocacy services posters are now prominently displayed on all noticeboards to ensure access to independent advocacy services. Complete and ongoing.
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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 14(1)	There shall be a person in charge of a designated centre.	Not Compliant	Orange	16/01/2023
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	16/01/2023
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.	Substantially Compliant	Yellow	19/12/2022
Regulation 19(3)	The directory shall include the information	Not Compliant	Orange	19/12/2022

	specified in paragraph (3) of Schedule 3.			
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	20/02/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	16/01/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	16/01/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections	Substantially Compliant	Yellow	01/02/2023

	published by the Authority are implemented by staff.			
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	19/12/2022
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	19/12/2022
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Not Compliant	Orange	16/01/2023
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's	Not Compliant	Orange	16/01/2023

	pharmacist regarding the appropriate use of the product.			
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.	Not Compliant	Orange	16/01/2023
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Not Compliant	Orange	13/01/2023
Regulation 34(1)(b)	The registered provider shall provide an accessible and effective complaints	Substantially Compliant	Yellow	19/12/2022

	procedure which includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	19/12/2022
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	19/12/2022
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise	Substantially Compliant	Yellow	19/12/2022

	it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	01/02/2023
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	19/12/2022
Regulation 9(3)(c)(iv)	A registered provider shall, in so far as is reasonably practical, ensure that a resident voluntary groups, community resources and events.	Substantially Compliant	Yellow	19/12/2022