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:	25 February 2021
Centre ID:	OSV-0005421
Fieldwork ID:	MON-0032146

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:	40

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
Thursday 25 February 2021	11:00hrs to 18:30hrs	Catherine Sweeney	Lead

What residents told us and what inspectors observed

Residents in Sonas Ard na Gréine told the inspector that they were well looked after and that staff were kind to them. They were familiar with the management team and told the inspector that they could speak with the person in charge or any member of staff if they had any problems or complaints.

The inspector observed some residents mobilising independently around the centre and using all the communal areas including multiple day rooms, a conservatory, an oratory and a large dining room. The residents in the conservatory told the inspector that they enjoyed the views over the sea. The inspector observed a number of residents with complex social and emotional needs spending long times alone in their bedrooms. Opportunities for recreation or activities was not identified in the care plans of these residents.

The layout of the centre posed a challenge in terms of both staffing and the facilitation of social engagement in the centre. Some bedrooms were observed to be small and the layout of some rooms did not promote the independence of residents. For example, there was no room to place the residents bedside locker beside their bed.

A building and refurbishment project was on-going in the centre at the time of inspection. The provider was planning to increase the number of bedrooms in the centre and increase the size of a number of existing bedrooms. A plan was also in place to increase the size of one of the day rooms. The building works had been risk assessed and the residents had been kept up to date with on-going building works and informed of any disruption to their quality of life that the building works may bring. The inspector observed to works had been managed in a way that reduced the disruption to the residents.

The on-going COVID-19 restrictions meant that residents congregated in small groups around the centre. There was staff available to encourage social engagement however, the layout of the centre did not facilitate opportunities for group activities. To provide supervision and support to all residents, staff were required to move around the communal rooms and to the residents individual bedrooms. The inspector observed an incident where a resident waited an extended period of time to be attended to. The resident was observed calling and tapping their table to get staff attention as they did not have access to their call bell. The resident told the inspector that they often have to wait when they need assistance.

Due to the COVID-19 infection control restrictions in place, space in the communal dining room was limited. The inspector observed residents being served their meals in the day rooms and in their bedrooms. Residents told the inspector that they enjoyed the food and that they were offered choice at mealtimes. Meals were observed to be appetising and nutritious. A review of residents meetings found that residents had requested a review of the menus. The action taken to address this

issue was was not documented. However, the person in charge explained that the menus had been revised and approved by a dietitian.

Capacity and capability

This was an unannounced risk inspection by an inspector of social services to monitor compliance with regulations and to follow up on the action from a previous inspection in March 2019. This inspection took place during the COVID-19 pandemic. National level 5 restrictions were in place. The centre had an up-to-date COVID-19 contingency plan which was reviewed by the person in charge on a weekly basis. The centre had remained free from COVID-19 since the start of the pandemic. This inspection found that overall, the health and social care of the residents was in compliance with the regulations, however, improvements were required in training and supervision of staff and the overall management of records, including complaints, to ensure clear and effective oversight of the entire service.

Some actions had been addressed from the previous inspection. There was an increase number of activity coordinators employed, documentation of residents social activity was recorded and signage in the centre had improved. However, a number of actions remained outstanding. The activity schedule required review to ensure that is was appropriate and effective for all residents in the centre. The inspector was advised that the outstanding actions in relation to room configurations would be addressed as part of the on-going refurbishment of the centre due to be completed in May 2021.

The provider of this centre in Sonas Asset Holdings Limited. The person in charge was newly recruited to the post in January 2021, having previously been in the role of clinical nurse manager. The person in charge was well known to the residents and demonstrated a good knowledge of residents assessed care needs. The person in charge was supported by a regional manager and a quality and governance co-ordinator.

The statement of purpose required immediate review to ensure that the information in relation to the number of registered beds in the centre was correct. The statement of purpose stated that the centre was registered for 50 beds. The centre is registered for 49 beds.

Improvement was required in the management of information. The systems in place made it difficult to retrieve the information requested on the day of inspection. For example, the risk management system was initially presented for review on an on-line platform. However, on review some risk assessments, for example, the infection control risk assessment had been saved to files on a laptop. The management staff were not clear as to which of the risk assessments was valid and up-to-date. in addition, a review of a file of a newly recruited member of staff found that the file

did not contain a Garda (police) vetting certificate on file. This certificate was later retrieved by the administrator and put on file during the inspection. The management team could not provide assurance that the information given to the inspector for review was the most up-to-date version of a number of documents requested. This issue was repeated in relation to

- resident records,
- training records,
- staff files,
- statement of purpose,
- residents incidents record,
- resident meeting notes.

On the day of the inspection there were 40 residents accommodated in the centre, one of whom was in hospital. Of these, 10 were assessed to require maximum levels of care, 23 required high levels, five medium and two residents requiring low levels of care. There were two nurses on duty during the day, supported by a clinical nurse manager and the person in charge. Nurses were supported by a team of 10 care assistants during the day. There was one nurse on duty with three care assistants during the night. This night time staffing level required review to ensure that there was adequate nursing resources on duty at night time to meet the assessed needs of the residents and for the size and layout of the building.

A review of the training matrix found that there were significant gaps in the training completed. Staff did not have up-to-date training provided in Safeguarding vulnerable adults, or for residents with responsive behaviours. Significant gaps were also noted in safe manual handling practice. This posed a risk to residents in the centre whose assessed needs included management of complex behaviours. All staff had completed training in fire safety and infection control practice.

While some staff files reviewed contained evidence of a comprehensive induction for new staff and on-going staff appraisals, others did not evidence any induction or appraisals. The inspector was informed by the management staff and by staff spoken with that induction and appraisal took place, however the documentation of this was inconsistent and did not allow for review and progress to be evidenced. This inconsistent approach to record keeping made it difficult to assess if all staff were appropriately supported and supervised.

There was a clearly defined management structure in the centre. Lines of authority and accountability, and roles and responsibilities were understood by all staff. The provider had management systems such as risk management, electronic nursing documentation, auditing and management and staff meetings in place to ensure that the service provided was safe and effectively monitored. However, a review was required to ensure that the quality of the documentation and recording of these systems facilitated quality improvement in the centre.

A schedule of organisational audits was completed in areas such as infection prevention and control, hospitality, falls and incidents and care plans. A review of these audits found that while information is collected, it is not sufficiently analysed

to develop clear quality improvement plans that have appropriate time lines and are are allocated to appropriate personnel.

The centre has a complaints policy and procedure in place that reflect the requirements under regulation 34. A review of the complaints log found that complaints are documented. However, the investigation of complaints, the learning identified and the satisfaction of the complainant is not documented. It is therefore not possible to identify how the management of complaints can be used to identify and implement improvements in the service.

Regulation 15: Staffing

A review of night-time nursing staff levels was required to ensure that all residents could be monitored and supported in line with their assessed care needs.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Significant gaps in training was identified. Most staff did not have up-to-date training in safeguarding vulnerable adults or in the management of challenging behaviour. This posed a risk to residents who had symptoms of disease which included responsive behaviours.

Judgment: Not compliant

Regulation 21: Records

A review of the information governance systems in the centre was required. Information requested throughout the inspection was not produced in a timely and efficient manner. The management team did not appear to have a system of information management that ensured that all records kept in the centre were up-to-date and correct.

Judgment: Not compliant

Regulation 23: Governance and management

A review of the management systems in the centre was required to ensure that information documented as a result of auditing, risk assessment, or complaints was analysed and that quality improvement plans were developed where learning needs had been identified.

Judgment: Not compliant

Regulation 3: Statement of purpose

A review of the statement of purpose for the centre found that Condition 3 of the registration of the centre was incorrect. The statement of purpose stated that the maximum occupancy of the centre was 50. The centre was registered for 49 residents. The room narrative also described room one as being a double room when it is registered as a single room.

Judgment: Not compliant

Regulation 34: Complaints procedure

A review of the complaints register found that investigation of complaints and the follow up communication with the complainant to establish satisfaction is not documented in line with the requirements under regulation 34.

Judgment: Not compliant

Quality and safety

Overall, the health care needs of the residents were met to a satisfactory standard. However, improvement was required to ensure that the activity and social engagement schedules were appropriate to meet the needs of the residents.

This inspection took place during the COVID-19 pandemic. The provider had a centre-specific COVID-19 contingency plan in place which was reviewed and updated weekly by the person in charge and the clinical nurse manager. Protocols were in place to ensure infection prevention and control measure could be maintained. All staff were monitored for symptoms prior to entering the centre.

The centre was clean on the day of inspection. A cleaning schedule was in place and this was maintained and signed by the cleaning staff. All staff in the centre had received up-to-date infection prevention and control training including hand hygiene,

and the safe use of personal protective equipment (PPE).

The centre had a risk management policy that contained the detail required under regulation 26. A review of the risk register found that hazards were identified and control measures were in place to mitigate against the risks identified. Both environmental and clinical risks were identified within the risk register. A specific infection control risk assessment was in place to address the risks posed by the COVID-19 pandemic.The recording of the risk register required review as discussed under regulation 21, Records.

An electronic nursing documentation system was used to document resident care. Care staff had access to residents assessments and care plans. A review of a sample of residents notes found that all residents had a comprehensive assessment recorded and a care plan developed based on the recorded assessment. Care plans reviewed were detailed and person-centred.

The centre has access to a local general practitioner (GP) service. Access to GP's has remained unrestricted throughout the pandemic period. Residents are also supported by allied health care professionals such as physiotherapy, dietitian, speech and language therapy palliative care supports and psychiatry of later life.

The layout of the centre, with multiple communal areas for the residents, the restrictions in place during the COVID-19 pandemic and the complex nature of many of the residents care needs, made the facilitation of social engagement challenging. There was an activities schedule in place that was facilitated by an activity co-ordinator however, as there was no central area for activities, and residents were supported for short periods of time in small groups or individually, reducing their opportunity for social engagement.

The person in charge was in the process of completing one-to one meetings with residents in the centre. During these meetings residents were asked about their views on the opportunities for social engagement, food and dining experience, and their quality of life in the centre. Feedback from these meetings was generally positive, however, where the residents had made suggestions, there was no documentary evidence that the suggestions had been followed up.

The last recorded resident's meeting in the centre was on October 2020. Again, there was no evidence that suggestions made by residents at the meeting were considered or implemented. For example, residents asked for more meal options and for the menus to be reviewed. There was no evidence that any action had been taken to address the issue.

A residents survey had been completed in December 2020, the results of which were mostly positive.

Regulation 11: Visits

This inspection took place during the COVID-19 pandemic. The provider continued to facilitate window and booth visits throughout level five restrictions. Visits took place in line with the guidelines from the Health Protection Surveillance Centre (HPSC).

Judgment: Compliant

Regulation 17: Premises

The size of a number of the bedrooms in the centre did not meet the needs of residents accommodated. The layout of some rooms did not facilitate independent mobility and access to personal belongings. For example, in one room a resident did not have immediate access to their bedside locker due to the fact that there was limited space between the resident's bed and the bedroom door. The locker was located at the end of the resident's bed.

A plan was in place and, there was building work on-going, to ensure that the size of resident's bedrooms complied with the upcoming changes in the regulation under SI No.293. The plan completion date for these works was May 2021.

Judgment: Substantially compliant

Regulation 26: Risk management

The provider had a system in place to identify environmental and clinical risk and put controls in place as required. A review of the risk management policy found that it contained all the detail required under regulation 26.

Judgment: Compliant

Regulation 27: Infection control

The provider had systems in place to ensure the prevention and control of infection. The systems in place were in line with the Health Protection Surveillance Centre (HPSC) Interim Public Health, Infection Prevention and Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Each resident had an individual assessment completed and care plans were informed by the assessments. Care plans reviewed were person-centred and provided the detail required to care for the residents.

Judgment: Compliant

Regulation 6: Health care

A review of the residents medical notes found that recommendations from the residents doctors and allied health care professionals were integrated into the residents care plans.

Judgment: Compliant

Regulation 9: Residents' rights

The size and layout of the building and the complex nature of the residents health care needs resulted in residents spending long periods of time alone in their bedrooms or with a small group of fellow residents. The layout of the communal areas require review to ensure facilitating of a positive social environment.

Action taken to address recommendations and suggestions made by residents was not documented and reviewed by the management team.

Some residents did not have adequate access to their personal belongings due to layout of their bedroom furniture.

Judgment: Not 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 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Not compliant

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

Inspection ID: MON-0032146

Date of inspection: 25/02/2021

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Safe and suitable staffing is maintained at all times and during the pandemic this was kept under constant review by the home management team, the quality team and the HR team. Rosters are reviewed and adjusted in line with reduced or increased occupancy. Additional nursing staff had been recruited prior to the inspection. They have now commenced and are completing their inductions. 31/05/2021. The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations.	
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 company has recently introduced a new training management system. Therefore, some records were difficult to retrieve as they were housed in both the old system and the new system. The synchronisation of all records will be complete by 31/05/2021. Refresher education has commence with staff .All staff will have up-to-date mandatory training and the records will be updated. 31/05/2021.	

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
The company is moving to paperless systems in order to go green. We aim to have all records transferred and easily retrievable by 31/05/2021.

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The company is moving to paperless systems in order to go green. We aim to have all records transferred and easily retrievable by 31/05/2021.

New METRICs and Quality Improvement Plan templates were introduced in January 2021. The home management team are familiarising themselves with same. This is an ongoing development.

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
There was a typo in the SOP which was corrected on the day of the inspection.

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
All concerns, complaints and compliments are now filtered on the software system used for recording same and a quarterly analysis with the Quality Manager will ensure that the outcome and/or complainants satisfaction is recorded in the correct place on the software system. The complaint reviewed on the day of the inspection had the outcome recorded in the family communication section of the electronic record and was not also recorded in the complaints section. This has been addressed.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The home is undergoing refurbishment and extension and this will enhance the home for all residents. We will continue to seek resident feedback and involvement re. same. 31/05/2021.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Due to the Pandemic, residents are allocated to pods. Large group activities cannot take place at present until further advice from public health is issued. Small and effective group activities take place and residents are grouped according to their interests and abilities. All residents in their rooms have one-to-one activities. The activities schedule is reviewed constantly in line with public health advice and ongoing home risk assessment. The annual residents survey revealed that residents are happy with their bedrooms. Current refurbishments will enhance facilities further. We will continue to seek resident feedback and involvement re. same. 31/05/2021.

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations.

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 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	31/05/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	31/05/2021
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	31/05/2021
Regulation 21(1)	The registered	Not Compliant	Orange	31/05/2021

	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.			
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	31/05/2021
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	31/05/2021
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint,	Not Compliant	Yellow	31/05/2021

	the outcome of the complaint and whether or not the resident was satisfied.			
Regulation 34(1)(g)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant promptly of the outcome of their complaint and details of the appeals process.	Not Compliant	Yellow	31/05/2021
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.	Not Compliant	Yellow	31/05/2021
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Yellow	31/05/2021
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted	Not Compliant	Yellow	31/05/2021

	about and participate in the organisation of the designated centre concerned.			