Health Information and Quality Authority
Social Services Inspectorate

Registration Inspection report
Designated Centres under Health Act 2007

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Sonas Care Centre Ard na Greine
Centre ID:	0385
Centre address:	Ard na Greine Enniscrone Co. Sligo
Telephone number:	096 37840
Fax number:	09637841
Email address:	ard@sonas.ie
Type of centre	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Sonas Nursing Home Management Company Ltd
Person authorised to act on behalf of the provider:	John Mangan
Person in charge:	Margaret Mc Phee
Date of inspection:	8 and 9 June 2011
Time inspection took place:	**Day 1: Start:** 09:30 hrs **Completion:**18:15 hrs **Day 2: Start:** 09:15 hrs **Completion:**15:00 hrs
Lead inspector:	P.J Wynne
Support inspector	Damien Woods
Type of inspection:	☒ **Registration** ☒ **Announced** ☐ **Unannounced**

About registration

The purpose of regulation is to protect vulnerable people of any age who are receiving residential care services. Regulation gives confidence to the public that people receiving care and support in a designated centre are receiving a good, safe, service. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected.

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

Under section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.

As part of the registration process, the provider must satisfy the Chief Inspector that s/he is fit to provide the service and that the service is in compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2009 (as amended).

In regulating entry into service provision, the Authority is fulfilling an important duty under section 41 of the Health Act 2007. Part of this regulatory duty is a statutory discretion to refuse registration if the Authority is not satisfied about a provider's fitness to provide services, or the fitness of any other person involved in the management of a centre. The registration process confirms publicly and openly that registered providers are, in the terminology of the law, "fit persons" and are legally permitted to provide that service.

Other elements of the process designed to assess the provider's fitness include, but are not limited to: the information provided in the application to register, the Fit Person self-assessment, the Fit Person interviews, findings from previous inspections and the provider's capacity to implement any actions as a result of inspection.

Following the assessment of these elements, a recommendation will be made by inspectors to the Chief Inspector. Therefore, at the time of writing this report, a decision has not yet been made in relation to the registration of the named service.

The findings of the registration inspection are set out under eighteen outcome statements. These outcomes set out what is expected in designated centres and are based on the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended); the *National Quality Standards for Residential Care Settings for Older People in Ireland*. Resident's comments are found throughout the report.

The registration inspection report is available to residents, relatives, providers and members of the public, and is published on www.hiqa.ie in keeping with the Authority's values of openness and transparency.

About the centre

Location of centre and description of services and premises

The centre is located within walking distance of the centre of Enniscrone. Ard Na Greine is built on an elevated site overlooking the town.

Sonas Care Centre is a purpose-built facility for the dependent people. It is a two-storey complex, providing long-term, convalescent and respite care for up to 58 residents including those who have dementia care needs. The layout, furniture and décor are coordinated, bright, clean and modern.

Accommodation comprises 38 single rooms of which 25 are en suite. There are ten twin en suite rooms. All en suites include a toilet, shower and wash-hand basin. Ard na Greine has communal and private areas including four comfortable sitting rooms, two dining rooms and an oratory.

There are two enclosed gardens provided with seating and external areas landscaped for residents' use. There is ample designated vehicle parking provided to the front of the building which is clearly sign-posted.

Date centre was first established:			5 May 2002	
Number of residents on the date of inspection:			53 plus 1 in hospital	
Number of vacancies on the date of inspection:			4	
Dependency level of current residents:	**Max**	**High**	**Medium**	**Low**
Number of residents	36	13	5	0
Gender of residents			**Male (✓)**	**Female (✓)**
			√	√

Management structure

Sonas Care, Ard Na Greine is part of the Sonas Care Group. John Mangan who is a member of the Board of Directors is the nominated Provider on behalf of the company.

The Person in Charge, Margaret Mac Phee, reports to the Provider, who in turn reports to the Board of Directors. The Person in Charge is supported by an assistant director of nursing and has a team of nursing, care, catering and housekeeping staff who report to her.

Summary of compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

This report set out the findings of a registration inspection, which took place following an application to the Health Information and Quality Authority for registration under Section 48 of the Health Act 2007.

This was the third inspection of the centre undertaken by the Health Information and Quality Authority (the Authority). This was an announced registration inspection which took place over two days. An unannounced follow up inspection had previously been carried out by the Authority, Social Services Inspectorate on the 13 October 2010. An action plan detailing areas which required attention was forwarded to the provider post this inspection. As part of the registration inspection these actions were also reviewed by the inspectors. The last inspection report contained three actions and two recommendations. All actions and recommendations were satisfactorily completed.

Inspectors met with residents, relatives, and staff members over the two day inspection. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Separate fit person interviews were carried out with the provider and the person in charge, both of whom had completed the Fit Person self-assessment document in advance of the inspection. This was reviewed by inspectors, along with all the information provided in the registration application form and supporting documentation. Since completing the fit person entry programme they had undertaken a number of initiatives including the development of a preadmission assessment procedure reviewing the complaints procedure and updating the statement of purpose. A health and safety representative was appointed and staff had been trained in basic life support.

Overall, inspectors found evidence of good practice and a commitment by the centre's management team to continually work to improve the quality of the service that residents received. The health needs of residents were met. Residents had access to general practitioner (GP) services and to a range of other allied health professional services. Evidence-based nursing care was provided. Inspectors observed staff providing care for the residents in a knowledgeable, competent and respectful manner.

Daily routines and care practices provided residents with capacity to exercise autonomy and make choices. Residents could practice their religious beliefs freely. There was a good choice and a high quality of food available to residents. The dining experience was pleasant

Inspectors found some aspects of the service that needed improvement. There was a need for training of additional staff in the area of care of older people with dementia to meet the need of the current resident profile. Some polices required review to include the end of life, risk management and communication policy. Other areas identified for improvements included care-planning and residents involvement in their plan of care.

The Action Plan at the end of this report identifies improvements that must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009(as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Section 50 (1) (b) of the Health Act 2007
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

1. Statement of purpose and quality management

Outcome 1
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the statement of purpose, and the manner in which care is provided, reflect the diverse needs of residents.

References:
Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

Inspection findings

The statement of purpose accurately described the service that was provided in the centre and met requirements of Schedule 1 of the (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Inspectors found the statement of purpose accurately reflected the residents, services and facilities, the provider had included in the application to register.

The organisational structure outlined in the statement of purpose was reflective of practice within the centre. It showed that all staff were supported in their roles within the organisation.

The statement is kept under review by the provider and is made available to residents on admission, and following review.

Outcome 2
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

References:
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Inspection findings

Inspectors found that the quality of care was reviewed and monitored on an ongoing basis. The person in charge demonstrated a commitment to the regular auditing of care practices. The person in charge played a lead role in gathering and analysing data in areas such as falls, the use of bed rails, the number of residents who had weigh loss or gain and the number on psychotropic and or night sedative medication. The inspector reviewed the monthly audits on residents' vulnerability to falls. Protective measures were identified to mitigate risks to protect residents.

However, the quality improvement initiatives were not communicated to residents or their representative. The system did not provide for consultation with residents or their representative on safety of care and quality of life issues. Residents or their significant other had not participated in a satisfaction survey to ascertain their views overall on the on safety of care and quality of life in the centre.

Outcome 3
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Inspection findings

Inspectors found evidence of good complaints management practice. The person in charge maintained the complaints log. The inspector found that both verbal and non-verbal complaints were documented which included the investigations or actions undertaken to resolve the complaint. The complainant's satisfaction with the outcome was also clearly recorded.

The complaints policy was displayed in a prominent place and was summarised in the Residents' Guide and the statement of purpose.

Residents and relatives told inspectors they felt comfortable raising any concerns with the provider/person in charge or any member of staff should the need arise. Many residents and relatives said they never felt the need to complain.

The complaints policy was reviewed and was found to be comprehensive. The complaints procedure contained an independent appeals process.

2. Safeguarding and safety

Outcome 4
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.

References:
Regulation 6: General Welfare and Protection
Standard 8: Protection
Standard 9: The Resident's Finances

Inspection findings

Inspectors found that measures were in place to protect residents from being harmed or suffering abuse. All staff had received training on identifying and responding to elder abuse. A centre-specific policy was available which gave guidance to staff on the assessment, reporting and investigation of any allegation of abuse. The elder abuse policy contained a protected disclosure procedure. The assistant director of nursing was a qualified trainer in adult protection.

Staff were able to tell inspectors about the prevention of elder abuse policy, explain the different categories of abuse and state what they would do if they suspected abuse and the importance of taking measures to prevent the risk of abuse. There were no reports or allegations of abuse received by the Authority from the centre.

Questionnaires completed by residents and their relatives confirmed to inspectors that residents felt safe. They primarily attributed this to the staff being available to them at all times and the safety systems in place, such as call bells by their beds and in bathrooms. Some residents also commented that "staff check on them during the night and the front door is secured".

Outcome 5
The health and safety of residents, visitors and staff is promoted and protected.

References:
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Inspection findings

Overall inspectors found that systems and practices in place promoted the health and safety of residents, visitors and staff. There were systems in place for the management of a range of risk situations. There was a safety statement and a safety management structure in place. The health and safety policy included an environmental and clinical identification and assessment of risk throughout the centre. Precautions to control or minimise risk were specified. The inspector viewed staff signatures indicating they had read and understood the health and safety procedures. The inspector spoke with the staff health and safety representative, who had completed a safety course.

There was a missing person policy in place which included clear procedures to guide staff should a resident be reported as missing. Photographic identification was available for each resident. There were profile description sheet available for staff to provide to emergency services.

There was a food safety system in place and the inspector viewed records indicating staff had been trained in food safety.

The inspector viewed records in staff files which indicated all staff had been trained in the safe moving and handling of residents. There were arrangements in place for recording and investigating untoward incidents and accidents. A description of each fall by a resident was maintained. However, while vital signs were recorded where a resident sustained a fall un-witnessed or when observed to hit their head on falling, neurological observations were not recorded to determine if a head injury had been sustained and/or the level of consciousness affected.

The health and safety policy had not been reviewed since 2009 and did not include a governance procedure for formal arrangements to ensure learning for all staff from serious or untoward incidents or adverse events. For example, audits were undertaken to identify any potential risk, to include a check on the temperature of hot water and safety checks on bed rails to ensure they were they were correctly positioned. However, the audit records were not comprehensively documented and the information was not disseminated to all staff to ensure learning from past events.

While there was procedures to guide staff interventions in the event of self harm and aggression contained in the policy on behaviour management the procedures had not been included in the risk management policy. Furthermore, the risk management policy did not contain procedures to guide staff actions in the event of violence and assault.

A comprehensive emergency plan was in place to guide staff in responding to untoward events. A designated senior person was nominated to be the contact point in the event of an emergency. The plan outlined a clear procedure to follow in the event of fire, flooding and loss of electric power. Contingency arrangements were provided should it be deemed necessary to evacuate all the residents from the building. The contact numbers for the emergency services were on display and

contained within the plan. There was a visitors log in place to monitor the movement of persons in and out of the building to ensure the safety and security of residents.

Inspectors were provided with written evidence from a suitably qualified person confirming the building meets all the statutory requirements of the fire authority in relation to the use of the building as a residential centre for older people. Smoke detectors were located in all bedrooms and general purpose areas. Emergency lighting was provided throughout the building. An inspector viewed contracts of the servicing of fire alarms, smoke and heat detectors. These were serviced by a professional four times a year. Routine inspection of the automatic fire door closer and fire panel were undertaken to ensure they were operational. Fire fighting equipment was inspected frequently to ensure it was in place and intact. Plans to show the escape from to the nearest fire exit were displayed throughout the building.

There was a safe mechanism in place to evacuate immobile residents in the event of a fire. Each resident had been risk assessed to indicate the equipment required to safely evacuate the residents in the event of fire or other emergency situation. Fire evacuation sheets had been fitted to the beds of 43 residents. A staff member showed the evacuation sheet on a resident's bed to the inspector and explained competently, how it should be used. The inspector viewed records of fire drills which took place on a routine basis and included simulated evacuation techniques.

Outcome 6
Each resident is protected by the designated centres' policies and procedures for medication management.

References:
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Inspection findings

The inspector found evidence of good medication management processes. The inspector observed the nurses on part of their medication rounds and found that medication was administered in accordance with professional guidelines.
There were appropriate procedures for the handling and disposal of unused and out of date medicines.

All medication was reviewed by the prescribing doctor every three months or more frequently should a change in residents' health occur.

Controlled drugs were secured in a locked cabinet. An inspector viewed the controlled drugs register. Controlled drugs were checked by two nurses from opposing shifts, at the change of each shift to ensure all drugs were accounted for. A policy on medication management, to manage all aspect of medication from ordering, prescribing, storing and administering was available. The policy included

procedures for the disposal of unused or out of date medication. However, the maximum amount for PRN (as needed) medication was not indicated on all the prescription sheets.

3. Health and social care needs

Outcome 7
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

References:
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Inspection findings

Inspectors found a high standard of evidenced based nursing care and appropriate medical and allied health care. Residents were assessed and had care plans in place which were updated to meet their changing needs.

Residents were able to retain the services of their own GP. Ten GPs visited the centre on a regular basis. Evidence of advice from these service professionals was available in care records.

The provider/person in charge had ensured there was access to other allied health services such as physiotherapy, occupational therapy and chiropody. A review of care plans indicated residents had their and eyes tested routinely.
A review of case file indicated access to a range of appropriate health care professionals was facilitated to support residents' to achieve optimum health.
A review of case files indicated residents had access to speech and language therapy, dietetic services and a wound care professional. As there were difficulties accessing these allied health professionals promptly through the local community

services, the person in charge had sourced private services that could be utilised by residents.

An in house physiotherapist, who has worked at the centre for three and a half years, is on site two/three days each week. He had developed a good relationship with residents. The physiotherapist undertakes an exercise group and individual exercises for residents with particular problems. The inspector saw the programmes in place for residents with mobility problems and his considerate and patient dealing with residents in the centre.

There was evidence in care plans of good links with community mental health services. The psychiatrist for later life and the community mental health nurse attended the centre as required. Medication was reviewed routinely by the psychiatrist to ensure optimum health.

An inspector reviewed care plans relating to wound management and found evidence of good practice. Wounds were assessed and appropriate wound management care plans in place. The inspectors found that pressure relieving equipment was provided. Input by specialist services to include dietetics, occupational therapy and a wound care professional was obtained.

There was a range of equipment to enable nursing staff to respond to a medical emergency including an automated external defibrillator (AED) machine, oxygen supplies and a suction machine.

There was not clear evidence in the care plans of all residents or their representative being consulted on their plan of care or being involved when their care plan was reviewed or updated. Care plans had been reviewed and there was some narrative in the case files detailing the consultation. However, the narrative was not consistent with the timing of the care plan review or evident in all plans of care. There was evidence available of staff signatures to indicate when care plans were reviewed. However, where residents had dementia or were cognitively impaired, there was no narrative detailing an assessment of the resident's capacity to consent to the care plan in the case files reviewed.

There were a range of evidence based risk assessments in use to determine dependency levels, risk of falls, nutritional care, the risk of developing pressure sores, pain and mood assessments. However, there was poor linkage in reviewing and updating the care plans to these reviews. While staff knew residents well, there was limited evidence that an assessment of social care needs had been undertaken and there was no emphasis or prescribed interventions within care plans on the need to promote social aspects of care. The linkage between assessments and care plans focused on a medical model of care. Reference to personal and lifestyle choices was not evident in all care plans reviewed.

There was a structured program of activities in place which was facilitated by the activities coordinator, employed on a full time basis. The activities program included bingo, seat based exercises and craft making. On the first day of the inspection a musician visited, who was well known to the residents. The music was particularly appreciated by residents who joined in with many of the songs. Other

activities included a weekly keep fit class with the physiotherapist and visits by a volunteer with a dog. Vegetables were planted in the enclosed garden and residents told inspector they enjoyed watching them grow.

However, the staff member assigned to activities had not been facilitated with the opportunity for training in providing activities to residents, particularly those with cognitive impairment or behaviours that challenge. Staff were very familiar with residents like and dislikes. However, life histories had been completed with all residents. There was no detailed information on the residents' present and past interests, hobbies and pastimes to influence the activity program and ensure meaningful engagement for individual residents.

Outcome 8
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

References:
Regulation 14: End of Life Care
Standard 16: End of Life Care

Inspection findings

While there was no resident receiving end of life care at the time of inspection, the inspectors were satisfied that caring for a resident at end of life was regarded as an integral part of the care service provided. The local palliative care team provided support and advice when required and they will attend the centre outside of core hours.

The inspector reviewed care plans and noted personal wishes in relation to end of life care in some resident's care plans. However, the information was not sufficiently detailed in each case and requires further development.

The policy on the management of end of life care did not outline procedures to guide staff actions and interventions preceding death.

While there were no specific overnight facilities for family and friends. The inspector was told by the person in charge that relatives and friends could use a spare bedroom or a reclining chair if required.

Outcome 9
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

References:
Regulation 20: Food and Nutrition
Standard 19: Meals and Mealtimes

Inspection findings

Inspectors were satisfied that resident received a nutritious and varied diet that offered choice and mealtimes were unhurried social occasions that provided opportunities for residents to interact with each other and with staff.

The kitchen was suitable in size to cater for the residents' needs. It was clean, well equipped and contained suitable facilitates for the storage, preparation and cooking of food. It was well stocked with a plentiful supply of vegetables, fruit and meat. There was a good supply of juice including orange, prune and cranberry juice. The chef spoken to by inspectors was knowledgeable and enthusiastic about her role. She had attended a number of additional training courses to help her in her work.

The kitchen staff were informed which residents required their meals to be liquidised, where residents had difficulty swallowing. All portions in liquidised meals were individually plated and distinguishable. Those that required help were offered assistance sensitively and discreetly.

Inspectors saw residents being offered a variety of snacks and drinks. Jugs with a variety of juices and water were available in common areas and staff regularly offered drinks to residents. Residents told inspectors that they could have tea or coffee and snacks any time they asked for them.

There was a policy in place to guide and inform staff on the procedures to ensure residents' nutritional and hydration needs were met.The person in charge told the inspector all residents' weights were monitored routinely and a nutritional risk assessment was completed, which was viewed by the inspector in the residents' care plans. Where the assessment identified a risk, the resident was highlighted for more intensive supervision and appropriate intervention, such as a referral to a dietician. The inspector viewed evidence in case files of professional advise provided by dietetic services. There was specialist equipment available to record the weights of those residents unable to stand on a weighing scale. Those identified as being at risk of losing weight had their weight reviewed on a regular basis. Food and fluid intake was monitored and recorded.

4. Respecting and involving residents

Outcome 10
Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

References:
Regulation 28: Contract for the Provision of Services
Standard 1: Information
Standard 7: Contract/Statement of Terms and Conditions

Inspection findings

A signed contract was in place for each resident which detailed the care, services provided, fees to be charged and the term and conditions of occupancy. The cost of services not included in the fee such as hair dressing and chiropody were identified.

Outcome 11
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.

References:
Regulation 10: Residents' Rights, Dignity and Consultation
Regulation 11: Communication
Regulation 12: Visits
Standard 2: Consultation and Participation
Standard 4: Privacy and Dignity
Standard 5: Civil, Political, Religious Rights
Standard 17: Autonomy and Independence
Standard 18: Routines and Expectations
Standard 20: Social Contacts

Inspection findings

Residents' meetings took place monthly which gave some residents an opportunity to bring forward suggestions. Minutes reviewed by inspectors confirmed that discussions were held on topics such as activities and food. The provider and person in charge also mentioned that they met residents daily and encouraged them to voice any issues. Inspectors observed this to be the case. The provider and person in charge spoke to residents throughout the inspection and some residents referred to both on first name terms.

Residents confirmed to the inspection team that the centre was a good place to live and staff cared for them in a dignified and courteous manner. Residents were able to exercise choice regarding the time they got up and were able to have breakfast at a time that suited them. During the day residents were able to move around the centre freely and have visitors at any time. All residents had the option of a phone in their room. Residents who had not availed of this option were able to use a cordless phone which enabled them to take calls in the privacy of their own bedrooms. Some residents had their own mobile phones. Residents had access to a range of newspapers, magazines and journals which reflected their cultural interests and heritage.

There were notices boards located around the building containing information on the activities planned for the day and the complaints procedure. There was leaflets

provided containing information on how to prevent falls and on financial support available towards meeting the cost of care while staying in a residential centre.

Residents could practice their religious beliefs.There was a video link to the local church and Mass was relayed daily to the centre. Residents' had the option to watch the service in their own bedroom or in the day room. Funerals and Weddings were relayed which allowed residents' maintain strong links to the community. Some female residents' stated they especially enjoyed viewing the wedding ceremonies. Many of the residents lived locally prior to their admission to the centre and still knew many of the mass goers. One resident stated that he was pleased he could participate in the funeral ceremonies of local people he knew.

Residents' privacy and dignity was respected. Inspectors observed staff knocking on bedroom doors and waiting for permission to enter. Doors to residents" bedrooms were closed when care was in progress. All residents had been provided with a locker with a lockable drawer to allow them to secure personal items ensuring their privacy. Curtains were provided around beds in shared rooms.

There was a written operational policy and procedure on communication. The policy entailed the different modes of communicating and the ways that residents could be encouraged to express their needs. The policy outlined the procedure for communicating with residents with sight or hearing impairment and procedures for communicating with residents with cognitive impairment to include the use of talking mats and the Sonas program. However, staff had not been trained in the Sonas program. The inspector observed was a small number of residents with dementia who could not express themselves verbally. While there were some picture cards available, there were no specialist aids available such as talking mats referenced in the communication policy to support communication with residents who had dementia or difficulty expressing their needs verbally.

Outcome 12
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

References:
Regulation 7: Residents' Personal Property and Possessions
Regulation 13: Clothing
Standard 4: Privacy and Dignity
Standard 17: Autonomy and Independence

Inspection findings

The laundry was clean, well organised and had industrial sized washing machines and a dryer. The inspector spoke with a staff member who works full time in the laundry. She explained the procedures she follows to ensure that clothing is laundered appropriately and returned to residents. All clothes were marked to indicate ownership.

There was labelling machine which was used by laundry staff to label all clothes belonging to residents. Residents and their relatives said that their clothes were well taken care of by staff and clothes were laundered and returned promptly. Each resident had an individual wardrobe.

A property list was completed for each resident on admission. A subsequent list was maintained thereafter to record any additional property that may be brought in or returned home by the resident or their family

5. Suitable staffing

Outcome 13
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

References:
Regulation 15: Person in Charge
Standard 27: Operational Management

Inspection findings

The post of person in charge was full time and held by a registered nurse with the required experience as required by the Regulations. She had extensive experience and relevant knowledge on caring for older people and managing staff. She was a qualified general nurse and has been the person in charge since 2005.

The person in charge clearly identified her responsibilities in the provision of clinical care and the general welfare and protection of residents. The person in charge's knowledge of the Regulations and Standards and her statutory responsibilities was sufficiently demonstrated to inspectors both during the fit person interview and throughout the inspection.

Outcome 14
There are appropriate staff numbers and skill-mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

References:
Regulation 16: Staffing
Regulation 17: Training and Staff Development
Regulation 18: Recruitment
Regulation 34: Volunteers
Standard 22: Recruitment
Standard 23: Staffing Levels and Qualifications

Standard 24: Training and Supervision

Inspection findings

The provider employs 66 staff in total which includes a whole-time equivalent of 9 registered nurses and 21 care assistants. In addition, there is catering, cleaning, laundry, administration and maintenance employed. The inspector viewed the staff duty rota for a three week period. The rota showed the staff complement on duty over each 24-hour period. The person in charge at all times was denoted on the rota. The staff roster detailed their position and full name. The inspector noted that the planned staff rota matched the staffing levels on duty. Staff were observed to promptly respond to call bells during the day. The rota indicated the person in charge had sufficient time for management and governance tasks and to support and supervise staff. There was a formal nursing on call arrangement in place for outside of core hours to ensure there was a nominated person in charge outside of core hours. In the questionnaires returned to the inspectors all relatives said they found there was adequate staff on duty. The inspector was able to form the view that the numbers of staff on duty and skill mix were appropriate to meet the needs of residents on the day of the inspection. This included nursing staff, care staff, catering, and cleaning and laundry staff.

A senior nurse deputised for the person in charge when she was absent. Part-time staff did additional hours to cover other staff absences, so agency arrangements were not necessary. The review of the rota found that absences were sufficiently covered. There was a low staff turnover within the past 12 months ensuing continuity and consistency in care.

There was a recruitment policy in place. Staff confirmed to inspectors they undertook an interview and were requested to submit names of referees. A review of staff files indicated a signed contract of employment was in place for each employee. Staff confirmed they were provided with a code of conduct on commencement of employment. A signed copy was retained in the staff file viewed by the inspector. The code of conduct contained information on the observance of dignity and respect, confidentiality and the health and safety obligations. Job descriptions available for each staff grade and were clear and concise, outlining the reporting relationships, the purpose of the post and the principal duties and responsibilities appropriately.

There was a formal induction policy in place and records of induction training were maintained. Induction training was comprehensive and included orientation, review of health and safety policies, fire evacuation and infection control. The induction checklist was dated, signed by the employee and person in charge on completion of induction. Staff were only confirmed in post on completion of a satisfactory probation period the provider told inspectors.

A regular volunteer in the centre receive an acceptable level of supervision and support and was vetted appropriate to his role and level of involvement.

The provider maintained a record of An Bord Altranais PIN's (professional identification numbers) for all registered nurses. This was reviewed by inspectors and seen to be up to date. Fifteen of the 21 care assistants had completed Further Education and Training Awards Council (FETAC) Level 5 training.

The provider and person in charge were committed to providing on going training to staff, and both participated in training events. Mandatory training which included safe moving and handling of residents, adult protection and fire safety was completed by all staff. In addition, a range of modular training was undertaken by accredited trainers and an inspector reviewed the certificates issued by trainers in staff files. This included cardio-pulmonary resuscitation techniques, care of the older person, wound care and food safety.

There were 25 residents with a diagnosis of confusion, cognitive impairment or Alzheimer's and others with conditions that related to behaviours that challenge. While some staff were provided with specialist training in care of the elderly with dementia to guide their interactions and interventions, there was an insufficient number of staff trained to meet the needs of the resident profile to ensure the best outcome for all residents.

A sample of six staff files were examined to assess the documentation available, in respect of persons employed. While the majority of the information was in place there were not three written references in place in respect of each employee. Inspectors observed that Garda Siochana vetting was absent for six staff. The person in charge told the inspector that vetting had been submitted for all staff and was awaiting an outcome for the remaining six staff.

6. Safe and suitable premises

Outcome 15
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Inspection findings

The centre was specifically built to meet the needs of dependent people. The driveway was covered with tarmac and the grounds were landscaped. There are two enclosed gardens provided with seating available for use by residents. Handrails were fitted to both sides of the corridors to assist the independent movement of residents around the building. All entrance and exit doors were ramped ensuring ease of access for residents with mobility impairment. Doorways and corridors in particular throughout the building, were of suitable width to

accommodate wheelchair users. Safe floor covering was provided throughout the building .The inspector observed residents move freely around the building.

There was a call bell system in place at each resident's bed with which residents were familiar and found easy to use. Bedrooms and communal areas were found to be comfortably warm. There was under floor heating throughout the building with individual thermostats located in each bedroom allowing the heat level to be adjusted to suit individual needs. There were controls in place to ensure the temperature of the hot water at the point of contact does not exceed 43°C. A mixing valve had been fitted and preset to ensure temperatures do not exceed recommended limits. Testing of the water indicated it did not pose a scald risk.

The en suite facilities in bedrooms and other bathroom located off corridors were suitably adapted to meet the comfort and assessed needs of residents. All showers and toilets were provided with grab support rails and an emergency call system. Showers were level with the floor finish providing ease of access. Bathrooms were maintained in a clean condition and were ventilated mechanically. Toilets were located close to day rooms for residents' convenience and they did not have to return to their bedroom to use the bathroom.

The premises were maintained in a very clean condition. Cleaners were provided with suitable equipment. Separate colour-coded equipment was used to minimise the risk of spread of infection. Appropriate cleaning chemicals were used including a sanitizer. Sluice rooms were well equipped with stainless steel sinks, wash hand basins and storage areas for bedpans. A bed pan washer was provided.

A maintenance person was employed to undertake repairs and ensure the building and services were well maintained. There was a maintenance log book available for staff to record details of any equipment, or item that required repair on a routine basis.

Inspectors found there was appropriate assistive equipment available such as specialised beds, hoists, pressure relieving mattresses, wheelchairs and walking frames. There was a service maintenance contract in place, which covered breakdown and repair for all beds, air mattresses and other equipment, used by residents. Inspectors reviewed maintenance records and found that the equipment was maintained and serviced regularly by a qualified contractor.

Staff facilities were provided which included toilets and a shower. Separate toilet facilities were provided for catering and care staff in accordance with best practice for infection prevention.

Bedrooms were well furnished and equipped to assure the comfort and privacy needs of residents. However, a small number of bedrooms were not of adequate size to meet the individual needs of residents. The provider told the inspector planning permission had been obtained to alter certain bedrooms sizes.

Visitors primarily met with residents in the communal sitting room. Adequate arrangements were not in place for residents to receive visitors in private. While there was an area designated as a visitor rooms this was being utilised as day

room. There was not an area, separate from the resident's own bedroom, to meet visitors in private. Inspectors spoke to residents who stated that they met their relatives in either the resident's bedroom or communal areas.

Improvements had been made since the last inspection to provide more storage space and corridors were noted to be free of equipment. However, there was not adequate storage space to ensure equipment and assistive devices were stored in a discreet and safe manner. Trolleys for laundry and hoists were stored in the bathroom restricting use by residents and posing a possible infection or trip hazard.

7. Records and documentation to kept at a designated centre

Outcome 16
The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

References:
Part 6: The records to be kept in a designated centre
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

Inspection findings
** Where "Improvements required" is indicated, full details of actions required are in the Action Plan at the end of the report.*

Resident's guide

Substantial compliance ☒ Improvements required* ☐

Records in relation to residents (Schedule 3)

Substantial compliance ☒ Improvements required* ☐

General records (Schedule 4)

Substantial compliance ☒ Improvements required* ☐

Operating policies and procedures (Schedule 5)

Substantial compliance ☐ Improvements required* ☒

The provider had all the policies required in Schedule 5 of the Regulations with the exception of the policy on temporary absence and discharge of residents. Inspectors viewed a sample of polices and found that the majority were well written and guided practices such as the policy on the monitoring and documentation of nutritional intake, the missing person policy and the policy on prevention, detection and response to abuse. However, as stated in outcomes three, five, eight and eleven some policies did not sufficiently inform practice.

Directory of residents

Substantial compliance ☒ Improvements required* ☐

Staffing records

Substantial compliance ☐ Improvements required* ☒

All staff records reviewed did not contain the information as required in Schedule 2 of the Regulations as detailed under outcome 14

Medical records

Substantial compliance ☐ Improvements required* ☒

As stated in outcome six the maximum amount for PRN (as needed) medication was not indicated on all the prescription sheets.

Insurance cover

Substantial compliance ☒ Improvements required* ☐

Outcome 17
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

References:
Regulation 36: Notification of Incidents
Standard 29: Management Systems
Standard 30: Quality Assurance and Continuous Improvement
Standard 32: Register and Residents' Records

Inspection findings

Practice in relation to notifications of incidents was satisfactory.

The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. To date all relevant incidents had been notified to the Chief Inspector by the person in charge.

Outcome 18
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

References:
Regulation 37: Notification of periods when the Person in Charge is absent from a Designated Centre
Regulation 38: Notification of the procedures and arrangements for periods when the person in charge is absent from a Designated Centre
Standard 27: Operational Management

Inspection findings

There were appropriate arrangements in place for the absence of the person in charge.

The assistant director of nursing deputised for the person in charge. The provider was aware of his responsibility to notify the Authority but as yet this was not required.

Inspectors were informed that there have been no absences of the person in charge for such a length that required notification to the Chief Inspector.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider, the person in charge, and a member from the board of directors to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

REPORT COMPILED BY

P.J. Wynne
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

15 June 2011

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report*

Centre:	Sonas Care Centre Ard na Greine
Centre ID as provided by the Authority:	0385
Date of inspection:	8 and 9 June 2011
Date of response:	7 July 2011

Requirements

These requirements set out the actions that must be taken to meet the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care settings for Older People in Ireland*.

Outcome 2: Reviewing and improving the quality and safety of care

1. The provider is failing to comply with a regulatory requirement in the following respect:

The system for reviewing the safety of care and quality of life did not provide for consultation with residents or their representative.

Action required:

Consult with residents and their representatives in relation to the system for reviewing and improving the quality and safety of care, and the quality of life of residents.

Reference:

Health Act, 2007
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

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

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: We will update the system for reviewing the safety of care and quality of life. We will consult with residents and their representatives in relation to the system for reviewing and improving the quality and safety of care, and the quality of life of residents, through monthly resident forum, Newsletters and 3 monthly reviews and resident and relative satisfaction surveys.	1 August 2011

Outcome 5: Health and safety and risk management

2. The provider is failing to comply with a regulatory requirement in the following respect: Where a resident sustained a fall un-witnessed or when observed to hit their head on falling, neurological observations were not recorded to determine if a head injury had been sustained and/or the level of consciousness affected. The risk management policy did not include a governance procedure for formal arrangements to ensure learning for all staff from serious or untoward incidents The risk management policy did not contain procedures to guide staff actions in the event of violence and assault.
Action required: 1, Ensure a high standard of evidenced-based nursing practice is met with regard to residents who have sustained a fall.
Action required: 2, Ensure that the risk management policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.
Action required: 3, Ensure that the risk management policy covers the precautions in place to control the following specified risks: assault; aggression and violence; and self-harm.
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: 1. Neurological observations will now be completed on all residents who suffer head injury or unwitnessed fall. 2. Risk management policy has been updated to include a governance procedure for opportunities for learning. All adverse incidents will be discussed at staff meetings and corrective actions instigated and extra staff training put in place if indicated. 3. Risk management policy has been updated to include controls for incidents of Assault ,Aggression, violence and self harm	 Immediate Completed Completed

Outcome 6: Medication management

3. The provider is failing to comply with a regulatory requirement in the following respect: The maximum amount for PRN (as needed) medication was not indicated on all the prescription sheets.	
Action required: Indicate the maximum amount for PRN (as needed) medication on all the prescription sheets.	
Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicine Standard 14: Medication Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Maximum amount for PRN (as needed) medication is now included on all the prescription sheets.	 1 July 2011

Outcome 7: Health and social care needs

4. The person in charge is failing to comply with a regulatory requirement in the following respect:

There was not clear evidence in the care plans of all residents or their representative being consulted on their plan of care or being involved when their care plan was reviewed or updated.

Where residents had dementia or were cognitively impaired, there was no narrative detailing an assessment of the resident's capacity to consent to the care plan.

The linkage between assessments and care plans focused on a medical model of care.

The activity program did ensure meaningful engagement for all residents particularly those with cognitive impairment.

Action required:

1. Revise each resident's care plan, after consultation with him/her.

Action required:

2. Outline the conclusions of the discussion and agreement of the resident or their representative in the development of the care plan or its review in narrative format.

Action required:

3. Set out each resident's needs in an individual care plan developed and agreed with the resident.

Action required:

Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.

Reference:

Health Act, 2007
Regulation 8: Assessment and Care Plan
Regulation 6: General Welfare and Protection
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: Care plans will now illustrate all residents or their representative being consulted on their plan of care and being involved when their care plan is reviewed or updated. Comprehensive assessment completed on admission. Further risk assessments completed if required .Nurse will then form clinical judgment whether resident can consent to care plan and write narrative to justify his/her decision. Life stories will now be completed on all residents. Model of care will be refocused to encompass a bio psychosocial model. Comprehensive assessment completed on admission. Resident care evaluated monthly, Modular Nurse to coordinate 3 monthly resident reviews with multidisciplinary team and document results in resident review sheet. Activities coordinator will complete Sonas programme. All residents have specifically tailored exercise programmes devised by residents' physiotherapist. Sensory mobility activities programme now in place for all residents with cognitive impairment. Activities coordinator to complete Dementia activities course.	1 August 2011 Immediate 1 December 2011

Outcome 8: End of life care

5. The person in charge is failing to comply with a regulatory requirement in the following respect: Personal wishes in relation to end of life were not sufficiently detailed in each case and require further development. There were no specific overnight facilities for family and friends.
Action required: Review the assessment and documenting practices of resident wishes for end of life to ensure it contains appropriate information to fully inform staff.
Action required: Facilitate each resident's family and friends to be with them when they are dying and provide overnight facilities for their use.

Reference: Health Act, 2007 Regulation 14: End of Life Care Standard 16: End of Life Care	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Independent living unit on site are made available for family and friends to stay overnight. (non restricted visiting) Personal wishes in relation to end of life will be obtained particularly for those with no relatives. This may not be completed on admission but nominated staff member will speak to resident of relative and a suitable juncture	1 September 2011

Outcome 11: Residents' rights, dignity and consultation

6. The person in charge is failing to comply with a regulatory requirement in the following respect: There were no specialist aids available to support communication with residents who had dementia or difficulty expressing their needs verbally.	
Action required: Put in place practices that facilitate and encourage each resident to communicate.	
Reference: Health Act, 2007 Regulation 11: Communication Standard 17: Autonomy and Independence Standard 20: Social Contacts	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Talking mats picture boards, enhanced hearing aids, enlarged button phone, and enhanced visual aids to be purchased.	1 September 2011

Outcome 14: Suitable staffing

7. The person in charge is failing to comply with a regulatory requirement in the following respect: There was an insufficient number of staff trained in care of the elderly with dementia to meet the needs of the resident profile to ensure the best outcome for all residents.	
Action required: Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence based practice in care of the elderly with dementia	
Reference: Health Act, 2007 Regulation 17: Training and Staff Development Standard 24: Training and Supervision	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Staff Nurse to complete management and leadership in dementia care and will supervise dementia care All care and nursing staff to be trained in dementia Care.	 1 May 2010 1 July 2011

8. The provider is failing to comply with a regulatory requirement in the following respect: Three written references in place in respect of each employee. Inspectors observed that Garda Siochana vetting was absent for six staff.
Action required: Put in place recruitment procedures to ensure no staff member is employed unless full and satisfactory information and all documents specified in Schedule 2 have been obtained in respect of each person.

Reference: Health Act, 2007 Regulation 18: Recruitment Standards 22: Recruitment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All documents specified in schedule 2 will be obtained. Only documentation outstanding is 2 staff require Garda clearance and 2 staff require 1 reference	1 August 2011

Outcome 15: Safe and suitable premises

9. The provider is failing to comply with a regulatory requirement in the following respect: There was not an area, separate from the resident's own bedroom, to meet visitors in private. There was not adequate storage space to ensure equipment and assistive devices were stored in a discreet and safe manner. A small number of bedrooms were not of adequate size to meet the individual needs of residents.
Action required: Provide suitable facilities for residents to meet visitors in an area which is separate from the residents' own private rooms.
Action required: Provide suitable facilitates for the storage of all equipment.
Action required: Ensure the size and layout of rooms occupied or used by residents are suitable for their needs.
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: Additional storage space will be constructed in the next 6 months Received planning permission to extend room sizes Resident staff room beside oratory will revert to visitor's room and new extension will incorporate visitor's room for Atlantic view residents.	 1 January 2013

Outcome 16: Records and documentation to be kept at a designated centre

10. The provider is failing to comply with a regulatory requirement in the following respect: The provider had all the policies required in Schedule 5 of the Regulations with the exception of the policy on temporary absence and discharge of residents. As stated in outcomes three, five, eight and eleven some policies did not sufficiently inform practice.	
Action required: Put in place all of the written and operational policies listed in Schedule 5.	
Action required: Revise policies to inform contemporary evidence based practice.	
Reference: Health Act, 2007 Regulation 27: Operating Policies and Procedures Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Discharge policy updated to include temporary absences and discharge of residents procedures. Complaints policy updated Procedures for self harm and aggression, violence and assault have been included in the risk management policy. End of life policy updated.	 1 July 2011

Any comments the provider may wish to make:

Provider's response:

No response was received for this section

Provider's name: John Mangan

Date: 7 July 2011