

**Health Information and Quality Authority
Regulation Directorate**

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



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| Centre name: | Sonas Glendale Nursing Home |
| Centre ID: | OSV-0005417 |
| Centre address: | Shillelagh Road, Tullow, Carlow. |
| Telephone number: | 059 918 1555 |
| Email address: | picglendale@sonas.ie |
| Type of centre: | A Nursing Home as per Health (Nursing Homes) Act 1990 |
| Registered provider: | Sonas Nursing Homes Management Co. Limited |
| Provider Nominee: | John Mangan |
| Lead inspector: | Catherine Rose Connolly Gargan |
| Support inspector(s): | Leanne Crowe |
| Type of inspection | Unannounced Dementia Care Thematic Inspections |
| Number of residents on the date of inspection: | 46 |
| Number of vacancies on the date of inspection: | 14 |

About Dementia Care Thematic Inspections

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

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

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

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 27 April 2017 09:30 To: 27 April 2017 20:00

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

| Outcome | Provider's self assessment | Our Judgment |
|---|-----------------------------------|--------------------------|
| Outcome 01: Health and Social Care Needs | Compliance demonstrated | Substantially Compliant |
| Outcome 02: Safeguarding and Safety | Compliance demonstrated | Non Compliant - Moderate |
| Outcome 03: Residents' Rights, Dignity and Consultation | Compliance demonstrated | Non Compliant - Moderate |
| Outcome 04: Complaints procedures | | Compliant |
| Outcome 05: Suitable Staffing | Compliance demonstrated | Non Compliant - Moderate |
| Outcome 06: Safe and Suitable Premises | Compliance demonstrated | Non Compliant - Moderate |
| Outcome 08: Governance and Management | | Substantially Compliant |

Summary of findings from this inspection

This inspection was the first inspection of the centre since registration with the Health Information and Quality Authority (HIQA) under the new provider entity. This report sets out the findings of an unannounced thematic inspection which focused on specific outcomes relevant to dementia care in the centre. Inspectors also considered pre-inspection documentation forwarded by the provider/person in charge, notifications and other relevant information. Inspectors also reviewed the details of unsolicited information received by HIQA on 29 March 2017 regarding insufficient staffing levels, activities for residents, supervision of residents, cleaning procedures and security arrangements. This information was mostly substantiated on this inspection. Inspectors' findings are detailed throughout the report and are addressed in the report action plan.

As part of the thematic inspection process, providers were invited to attend information seminars given by the Authority. In addition, evidence-based guidance was developed to guide providers on best practice in dementia care and the inspection process. Prior to the inspection, the provider completed the self-assessment document by comparing the service provided with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Standards for Residential Care Settings for Older People in Ireland (2016).

The journey of a sample of residents with dementia within the service was tracked. Inspectors observed care practices and interactions between staff and residents who had dementia using a validated tool. Inspectors reviewed documentation such as nursing assessments, care plans, medical records and examined relevant policies including those submitted prior to inspection. All interactions between staff and residents observed by inspectors were respectful and kind with the exception of two staff interactions which were not person-centred as observed by inspectors. These observations were brought to the attention of the person in charge and operations manager on the day of inspection.

The inspectors met with residents and staff members during the inspection. Most residents who spoke with inspectors generally expressed their satisfaction and contentment with living in the centre, however a number of residents were dissatisfied with staffing levels to assist them with their personal care needs and opportunities provided for them to participate in activities. This information concurred with inspectors' findings and supported a review of staffing resources were required to ensure residents' assistive and activation needs were met.

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

Residents' accommodation in the centre was provided at ground floor level and residents with dementia integrated with other residents. The design and layout of the centre met its stated purpose with the exception of one communal sitting/dining room. Otherwise the centre provided a generally comfortable and therapeutic environment for residents with dementia. Work was underway to enhance colour schemes and to improve accessibility and signage for residents with dementia. Inspectors found that the management team and staff were committed to providing a quality service for residents with dementia. While there was evidence of effort made to ensure residents with dementia were supported and facilitated to enjoy a meaningful and fulfilling life in the centre, improvement was necessary in provision of suitable one to one and small group activities to meet the interests and capabilities of residents with dementia.

Inspectors found that the healthcare needs were met to a good standard. There were policies and procedures in place to safeguard residents from abuse. All staff

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

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

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

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

Findings:

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

The centre catered for residents with a range of dependency needs. On the day of this inspection, there were a total of 46 accommodated residents in the centre. Nineteen residents had dementia and five residents had symptoms of dementia. Inspectors focused on the experience of residents with dementia on this inspection. They tracked the journey of a sample of residents and also reviewed specific aspects of care such as safeguarding, nutrition, wound care and end-of-life care in relation to other residents with dementia in the centre.

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

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

physical, mental and psychological health, medications and nursing needs. The nutrition and hydration needs of residents with dementia were met; however, improvement was required in the dining arrangements in one of the two dining rooms. Residents were generally protected by safe medicine management policies and procedures but improvement was required to ensure medicine administration records were not completed until after the resident had taken their prescribed medicines in line with professional guidelines.

There was evidence that timely access to health care services was facilitated for all residents. The person in charge confirmed that a number of GPs were attending to the needs of residents in the centre; giving residents a choice of general practitioner. Residents attended out-patient appointments and were referred as necessary to the acute hospital services. Documentation reviewed and residents spoken with by inspectors confirmed they had access to GP care including out-of-hours medical care. Some residents who lived in the locality were facilitated to retain the services of the GP they attended prior to their admission to the centre. Residents had good access to allied healthcare professionals. Physiotherapy, occupational therapy, dietetic, speech and language therapy, dental, ophthalmology and chiropody services were available to residents as necessary. Community psychiatry of older age specialist services attended some residents in the centre with dementia and supported GPs and staff with managing residents' behavioural and psychological symptoms of dementia as needed. Residents' positive health and wellbeing was promoted with regular exercise as part of their activation programme, an annual influenza vaccination programme, regular blood profiling and medication reviews. Residents in the centre had access to palliative care services for support with management of their pain and for symptom management during end-of-life care if required.

There were systems in place to meet the health and nursing needs of residents with dementia. There was evidence of on-going work including staff training and auditing to ensure assessment and documentation of residents' needs was maintained to a good standard. The person in charge demonstrated recent improvements she and the staff team had made to ensure residents' needs were addressed. The majority of residents' needs were documented in care plans that were person-centred and informative. Inspectors found that one resident with BPSD and one resident with responsive behaviours did not have a behavioural support care plan in place. The behavioural support care plans that were in place required some improvement to ensure they clearly informed the behaviour experienced by the resident, triggers to the behaviour where identified and the effective intervention strategies staff should use to de-escalate any BPSD. The interventions to direct care actions in activation care plans required some improvement to clearly inform the scope of residents' individual interests and capabilities especially residents with levels of dementia that impacted on their ability to participate and benefit from group activities.

Assessments of residents' needs were carried out within 48 hours following admission and care plans were developed based on assessments of need and thereafter in line with residents' changing needs. The assessment process involved the use of validated tools to determine each resident's risk of malnutrition, falls, their level of cognitive function and skin integrity among others. Care plans were updated routinely on a three to four monthly basis or to reflect residents' changing care needs as necessary.

Inspectors found that all staff spoken with were knowledgeable regarding residents' likes, dislikes and care needs. There was evidence of the involvement of residents and their families, and evidence that they were consulted with in relation to care plan development and reviews thereafter.

Staff provided end-of-life care to residents with the support of their medical practitioner and the community palliative care services as necessary. There were no residents in receipt of palliative care services at the time of this inspection. A pain assessment tool for residents, including residents who were non-verbal was available to support pain management. Inspectors reviewed some end-of-life care plans for residents and found that they outlined the physical, psychological and spiritual needs of residents. Residents' individual wishes regarding location for receipt of end-of-life care were also recorded. Advanced directives were in place for some residents regarding resuscitation procedures. This documentation recorded family input on behalf of the resident in most cases in the documentation reviewed. Residents had access to an oratory in the centre. Each resident was accommodated in a single bedroom which supported their privacy during end-of-life care. Residents' relatives were facilitated to stay overnight with them at the 'end of life' stage of their lives. Staff outlined how residents' religious and cultural practices were facilitated. Members of the local clergy from the various religious faiths provided pastoral and spiritual support to residents.

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

There were systems in place to ensure residents' nutritional needs were met and that they did not experience poor hydration. However, improvement in dining arrangements was found to be required to ensure residents had adequate space and could dine at a table if they wished in one of the two dining rooms provided. This finding is discussed in Outcome 6. A nutrition policy document was available and informed practice. Residents were screened for nutritional risk using the 'Malnutrition Universal Screening Tool' (MUST) assessment process on admission and were reviewed regularly thereafter. Residents' weights were checked routinely on a monthly basis and more frequently where residents experienced unintentional weight loss. Nutritional assessment and care plans were in place that outlined the recommendations of the dietician and speech and language therapist where appropriate. Systems were in place for recording and monitoring residents' nutrition and fluid intake where required. Inspectors found that

one resident needing support to maintain an appropriate fluid intake did not have the necessary amount of fluid they should consume over a 24 hour period stated in their care plan interventions. Inspectors saw that residents had a choice of hot meals for lunch and tea. Residents with dementia were supported to make an informed choice regarding their choice of meal by showing them sample meals of the menu on offer. Alternatives to the menu on offer, snacks and refreshments were provided. There were arrangements in place for communication between nursing and catering staff to support residents with special dietary requirements. Inspectors observed that residents on weight-reducing, diabetic and fortified diets, and residents who required modified consistency diets and thickened fluids, received the correct diets. Staff supported and provided discreet assistance to residents with eating their meals as necessary.

There were arrangements in place to review accidents and incidents involving residents in the centre. Residents were assessed on admission and regularly thereafter for risk of falls. There was evidence of identification and implementation of learning from reviews of falls. HIQA was notified of one incident of a resident falling and sustaining a fracture since 01 January 2017. Procedures were put in place to mitigate risk of further falls and residents at risk of falling were appropriately risk assessed with controls such as hip protection and sensor alarm equipment put in place.

There were written operational policies informing ordering, prescribing, storing and administration of medicines to residents. Inspectors found that practices in relation to prescribing, administration and medication reviews met with regulatory requirements. The maximum dosage of PRN (a medicine only taken as the need arises) medication permissible over a 24 hour period was stated by the prescriber. Medicines to be administered in a crushed format were individually indicated by the prescriber. Inspectors observed that staff were trained to administer subcutaneous fluids to treat dehydration in order to avoid unnecessary hospital admissions. No residents were prescribed subcutaneous fluid administration on the day of this inspection. The pharmacist who supplied residents' medications was facilitated to meet their obligations to residents. There were procedures for the return of out of date or unused medications. Systems were in place for recording and managing medication errors. Medicines controlled under misuse of drugs legislation and medicines requiring refrigerated storage were appropriately managed. Balances of controlled medicines were checked as required and balances checked by an inspector were correct. Monitoring of medication refrigerator temperatures was in place.

Judgment:
Substantially Compliant

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

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

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

Findings:

Procedures were in place to protect residents with a diagnosis of dementia and all other residents from being harmed or suffering abuse. A policy was in place to inform staff on the management of any allegations, suspicions or incidents of abuse to residents. There were systems in place to ensure that allegations of abuse were investigated, and that pending such investigations measures were in place to ensure the safety of residents.

While inspectors observed that the majority of interactions of staff with residents were respectful, supportive and kind, interactions by two staff members with residents required improvement to ensure they were person-centred. These observations were brought to the attention of the operations manager and the person in charge by inspectors on the day of inspection. Staff training records were made available to inspectors and referenced that all staff had received training on prevention of abuse and safeguarding vulnerable residents. Staff spoken with by inspectors were knowledgeable regarding types of abuse and their responsibility to report any allegations, suspicions or incidents of abuse. Staff spoken with also confirmed to inspectors that they had received safeguarding training and were aware of what to do if they suspected or were informed of an allegation of abuse or had suspicions that an abusive incident had occurred. There were no allegations or incidents of abuse under investigation at the time of this inspection. Inspectors observed that no allegations of abuse were recorded or notified to HIQA since the new provider took ownership of the centre. Residents told inspectors that they felt safe in the centre and that staff were respectful and kind towards them.

Some residents experienced behaviours and psychological symptoms of dementia (BPSD) evident in responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Inspectors observed that staff responded to most incidents appropriately and that the interventions they used to de-escalate the behaviours were person-centred and were generally reflected in residents' behaviour support plan. However, inspectors observed that staff did not effectively de-escalate one resident's responsive behaviour in line with best practice. This resident and one other resident with responsive behaviours as observed by inspectors did not have a behaviour support care plan in place. Improvements were also required to ensure behaviour support plans in place were clearly documented to ensure residents' support needs were clearly communicated to staff and evaluated. This finding is actioned in Outcome 1. The majority of staff had attended training on dementia care and managing behaviours that challenge.

There was evidence that staff were committed to and working towards achieving a restraint-free environment. A policy informing the use of restraint was available and was demonstrated in practice. The person in charge advised inspectors that there were no residents receiving PRN (a medicine only taken as the need arises) psychotropic medications to de-escalate responsive behaviours. Procedures were in place to ensure use of PRN psychotropic medicines were reviewed. The inspectors saw that bedrails were currently being used for a small number of residents, some of whom requested them to support their mobility and comfort while in bed. Appropriate 'enabler' equipment was available and used where possible as an alternative to a full-length bedrail.

Assessment of bedrail use was completed to determine need and to ensure safety of use in each case. There was evidence of alternatives tried to ensure full-length bedrail use was appropriate. There was also documentary evidence that residents were being checked while bedrails were in use. The staff team were working towards reducing the use of bedrails in the centre with low-low beds, additional equipment and further education for staff.

There were procedures in place for managing residents' money put in safekeeping. Residents had a lockable space in their bedrooms to secure their personal valuables if they wished.

Judgment:

Non Compliant - Moderate

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

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

Findings:

Residents with dementia were consulted with and participated in the organisation of the centre. Residents' meetings were held and these were attended by a number of residents with dementia. Minutes of the most recent meeting in February 2017 was reviewed by inspectors. The minutes indicated that issues or requests raised by residents were addressed and responded to.

While the quality of life of independent residents in the centre was enhanced by their participation in the activity programme provided, inspectors' findings indicated improvement was required to ensure residents with dementia were supported to engage in activities that suited their capabilities, interests and preferences. A newly recruited activities co-ordinator was working full-time in the centre. Together with a part-time activities co-ordinator, they were responsible for developing and providing an activity programme for all residents in the centre. Each resident's past interests were used to inform the overall activity programme facilitated in the centre. An average of three activities was scheduled in the mornings and three activities in the afternoon across the centre. On the day of the inspection, room visits, exercises, a skittles game and walks to dinner were scheduled in the morning. Mass in the centre had initially been scheduled for the afternoon but due to unforeseen circumstances could not go ahead. The activity co-ordinator on duty on the day of the inspection arranged for a group rosary to take place instead of mass, and a ball game and art work was arranged for smaller groups of residents. However inspectors' observations of the recreational activity sessions provided were that care staff were busy with providing other care tasks for residents and were unavailable to support less able residents with dementia to meaningfully participate in

the activities facilitated by the coordinators.

Records were maintained to document residents' participation in activities but did not evaluate residents' level of engagement in each activity; therefore it could not be determined whether residents with dementia were supported to participate in activities that suited their capabilities and interests. For example a 'tick-list' record was used to document that residents participated in activities such as mass/rosary, listening to the radio, 'chit-chat' and hand massage. This record did not detail the level of residents' engagement. The activities co-ordinator informed inspectors that they were planning to create more detailed records to inform the development of an activity programme that catered for residents less able to participate in group activities. Inspectors were told that recruitment was underway to employ volunteers to support one-to-one activities with residents.

An activity room which was called the 'sensory room' was located in the centre. Inspectors were told that this room was used for small group activities, one to one time and as a calm space for residents who needed private space to relax. Inspectors were told that this room was used infrequently as there were insufficient staff numbers to adequately supervise residents across the communal rooms. Inspectors observed that a mattress and a hoist were inappropriately stored in this room throughout the day of inspection. A large garden was adjacent to this sensory room but was also not accessible to residents at the time of the inspection as upgrade works were due to take place in the near future. Two internal outdoor spaces were accessible to residents, and inspectors observed these being utilised by several residents on the day of the inspection.

Inspectors observed the quality of interactions between staff and residents using a validated observational tool to rate and record these interactions at five minute intervals in both dining-rooms and two sitting-rooms. Scores for the quality of interactions are +2 (positive connective care), +1 (task orientated care), 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). The scores reflect the quality of the interactions with the majority of residents. Inspectors' observations concluded that while there was some evidence of positive connective care with individual residents, the majority of the interactions were task-orientated care with some instances of neutral care. During these observation periods, inspectors also noted that staff members interacting with residents in a manner that did not promote their dignity. While most staff members were observed to be courteous when addressing residents and visitors, and sufficiently discreet when attending to the needs of residents, these findings did not reflect a high standard of person-centred care. These observations were communicated to the person in charge and the operations manager on the day of inspection. This finding is actioned under Outcome 2.

Communication devices and aids were used by some residents to support their communication needs such as hearing aids and spectacles. A communication policy was in place but required improvement to inform the communication needs of residents with dementia. Communication care plans were in place for residents with dementia and were reviewed by inspectors. Wireless internet was available in the building, which could be accessed by both residents and visitors. Private telephones were installed in every resident's bedroom. A bus was available for residents' outings and the person in charge

spoke to inspectors about how this was used in the last number of weeks to transport three residents to bingo in the local day centre.

Residents were facilitated to exercise their civil, political and religious rights. The person in charge stated that residents were supported to vote, either in the centre or in their local polling centre. Residents with dementia were supported to observe or abstain from religious practice in accordance with their wishes. An oratory was available in the centre and residents were visited by clergy from their respective faiths on a weekly or fortnightly basis. The inspectors observed that staff got consent from residents for all care activities and gave them choice regarding their daily activities in the centre. Residents' privacy and dignity needs were met. The inspectors observed staff knocking on residents' bedroom doors and closing doors to bedrooms and toilets during personal care activities. There were arrangements in place for residents to receive visitors in private. The person in charge told inspectors that in order to support residents, visiting was discouraged at mealtimes and visitors adhered to this request. Visiting was not restricted at any other time and a record of visitors to the designated centre was available and maintained at the front entrance.

Advocacy services were available to residents. While no residents were currently availing of this service, the person in charge told inspectors that they had requested an advocate for a resident in the past.

Judgment:

Non Compliant - Moderate

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

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

Findings:

The centre had a policy and procedure for the management of complaints.

A summary of the complaints procedure was displayed at reception, which outlined the persons to whom people could direct their complaints. This summary included details of the independent appeals process available to complainants, should they be unsatisfied with the outcome of their complaint. Information regarding an advocacy service and the Ombudsman was also included in this summary.

There was a nominated person to investigate and manage complaints. A second person was nominated to ensure that all complaints were recorded and responded to appropriately.

Verbal and written complaints were recorded in a complaints log that was maintained in the centre. Inspectors reviewed this log and found that it contained all of the information required by the regulations. Complaints were found to be closed out in a timely manner, and the satisfaction of the complainant with the outcome of their complaint was consistently recorded.

Forms seeking comments regarding the nursing home were also located at the entrance of the nursing home.

Judgment:

Compliant

Outcome 05: Suitable Staffing

Theme:

Workforce

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

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

Findings:

The findings of this inspection did not provide assurances that the staffing levels provided met the assessed needs of all residents, including those with dementia.

Inspectors' observations throughout the day of the inspection indicated that staffing levels were not sufficient to provide person-centred nursing and social care. Inspectors observed staff failing to promptly attend to residents' personal care needs or answer call bells in a timely manner on a number of occasions throughout the day. There was insufficient staff available to ensure residents with dementia requiring assistance were supported to participate in the activities provided. Inspectors spoke with residents during the inspection and while most spoke positively about staff in the centre, some residents expressed dissatisfaction with how their activation needs were met and the timeliness with which staff assisted them with their personal care needs. The inspectors observed staff asking residents to wait for assistance to have their personal needs attended to, for example, one resident who requested to use the toilet had to wait for a short period of time until a staff member became available to assist them.

A planned and actual staff rota was in place, with changes clearly indicated. The roster reviewed by inspectors indicated that two nurses were rostered on duty at all times.

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

Evidence of up-to-date registration with An Bord Altranais agus Cnáimhseachais na hÉireann for all nursing staff employed in the centre was provided to inspectors.

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

A training programme was in place for staff which included mandatory training in fire safety, moving and handling practices and the prevention, detection and response to abuse. According to training records the majority of staff had completed up to date mandatory training in line with the regulations. Records indicated that many staff members had also completed training in dementia care and the management of responsive behaviours, however inspectors' observations indicated that some staff did not demonstrate this training in practice. Other training completed by staff included cardiopulmonary resuscitation, infection prevention and control, dysphasia care and training on restraint management.

Minutes from staff meetings indicated that the various staff grades met with the person in charge on a regular basis.

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

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

While the design and space provided for residents in the centre met its stated purpose, improvements in some areas were required to ensure the premises provided a therapeutic and accessible environment for residents with dementia.

The centre is a single storey premises. Residents' accommodation in the centre consists of 60 single bedrooms with en-suite toilet, shower and wash basin facilities. Residents had access to two dining rooms, one of which was designed in a sitting/dining room style with kitchenette facilities. The layout and space available in this communal room did not meet residents' needs comfortably for the following reasons;

- a partially dividing wall blocked the view of the television for some residents.

- seating arranged in front of a door obstructed residents' access to the enclosed garden from the sitting room
- the sitting/dining room was overcrowded. An inspector observed some residents in the room having difficulty accessing a dining table. One resident in an assistive chair rested her meal on a cushion on her lap and an inspector observed that she struggled to prevent her plate slipping off the cushion.
- the layout of the seating in the sitting/dining room spilled into the dining area of the room which hindered their participation in a recreational activity facilitated in the sitting area of the room.

There were two additional communal sitting rooms in other locations in the centre, one of which was designed as a sensory room for residents with dementia. This sensory room was not used by residents on the day of this inspection. Seating was also provided in the reception area. A multi-denominational oratory was also available in the centre for residents. Communal toilets and shower/bathrooms were conveniently located throughout the centre. The reception area was spacious with a reception desk. The person in charge's office was also located in this area and is therefore accessible to visitors negating cause during office hours to access residents' accommodation to contact key management staff.

Two enclosed communal courtyards and an enclosed garden area were provided for residents' use. One of the communal sitting rooms opened out into a large enclosed and interesting courtyard area. The courtyard had raised flower and vegetable beds which some residents enjoyed. Inspectors observed that the enclosed garden required maintenance and were told that maintenance was planned to ensure the enclosed garden was safe and accessible for residents in the coming months. While the garden required maintenance, it provided winding pathways through a varied and interesting environment that contained well arranged shrubbery, flowers and small trees. Outdoor seating was provided in all outdoor areas but required painting so residents could comfortably sit and relax in the outdoor areas.

While there were storage areas for residents' equipment, some residents' equipment was inappropriately stored in the sensory room in the centre. There was a significant malodour in a room used for storage of residents' wheelchairs and other transport equipment. Inspectors found that the malodour was also evident in the corridor immediately outside this room. This finding was brought to the attention of the person in charge by the inspectors.

Residents had sufficient storage space in their bedrooms. A repainting project had commenced in some corridors. Colours chosen were bright and helped with distinguishing the various corridors in the centre. Use of natural light was optimised in residents' bedrooms, communal area and along a main corridor. However, some corridors were dark and the floor surface in some areas was uneven. Although carpeting along the main corridor was replaced, carpets on other corridors were dark and worn. Inspectors were told by the operations manager that a carpet replacement programme was underway. Many residents' bedroom had carpets on the floors. There was a carpet cleaning schedule in place and no malodours were evident in the sample of residents' bedrooms visited by inspectors on the day of this inspection. Residents spoken with were satisfied with the standard of cleaning done in their bedrooms and en-suite

facilities. Handrails were located on all corridors and in showers and toilets. Bedrooms were equipped with a locker, chest of drawers, a wardrobe, a chair, a television and a bed for each resident. The inspector observed that many residents personalised their bedrooms with personal possessions and small items of furniture from their home. Inspectors were told that residents were encouraged to make their room 'their own' and to use items of their own furniture if they wished to enhance their comfort.

Judgment:

Non Compliant - Moderate

Outcome 08: Governance and Management

Theme:

Governance, Leadership and Management

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

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

Findings:

There was a clearly defined management structure in place and this reflected the information outlined in the centre's statement of purpose. Lines of authority and accountability were defined and all members of the team spoken with were aware of their roles, responsibilities and their reporting procedures. Governance meetings were held and minutes were made available to inspectors. The provider attended the centre monthly and together with the person in charge reviewed the quality and safety of the service. Team communication was promoted by regular meetings with staff.

Management arrangements and monitoring systems were in place to review the quality of care delivered to residents. There was evidence that regular review of key aspects of the service informed improvements and provided assurances that the service was safe and appropriate. For example, key areas of clinical care, the environment and feedback from residents and their relatives were reviewed. Inspectors' found that the information collated from the various reviews was analysed and actioned where necessary. Trending of findings in audits and reviews was done to inform proactive strategies in areas such as falls management, complaints and restraint management. However, the monitoring system in place did not ensure that appropriate staffing resources were provided to ensure residents' needs were effectively met.

The provider and clinical management team demonstrated that they welcomed feedback on the service provided from residents and relatives. The inspectors saw that a number of areas for improvement were raised in an annual relatives' satisfaction survey that were actioned by the provider and person in charge with positive outcomes for residents in the centre. For example, arrangements for laundering residents' personal clothing were revised to ensure they were managed appropriately, daily mass was provided via webcam from a local church among other improvements. While feedback from residents and relatives spoken with on inspection was generally positive, some did express

dissatisfaction with staffing levels and activities for residents. This concurred with inspectors' findings on this inspection that improvement in staffing resources was required. While inspectors' findings demonstrated that sufficient resources were made available to meet residents' needs in terms of facilities and assistive equipment to ensure effective delivery of care in accordance with the centre's statement of purpose, staffing resources available required improvement to ensure residents' needs were met. This finding is also discussed in Outcome 5.

Judgment:
Substantially Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

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

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

| | |
|----------------------------|-----------------------------|
| Centre name: | Sonas Glendale Nursing Home |
| Centre ID: | OSV-0005417 |
| Date of inspection: | 27th April 2017 |
| Date of response: | 5 th July 2017 |

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

One resident with BPSD and one resident with responsive behaviours did not have a behavioural support care plan in place.

The behavioral support care plans that were in place required some improvement to ensure they clearly informed management of the behavior experienced by the resident.

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

The interventions to direct care actions in activation care plans required some improvement to clearly inform the scope of residents' individual interests and capabilities, especially residents with levels of dementia who could not benefit from group activities.

Where residents required a care plan for fluid intake, the required fluid intake over a 24 hour period was not consistently specified in some residents' care plans reviewed by inspectors.

1. Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

All Care plans of residents with BPSD have been reviewed. The requisite assessments, mapping tools, behavioural support care plans agreed by all the stakeholders are in place.

Proposed Timescale: 05/07/2017

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

Inspectors observed that staff did not respond to one resident's BPSD in line with best practice.

2. Action Required:

Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

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

: All staff are trained in Dementia care and managing responsive behaviours. All BPSD care plans have been reviewed, Episodes of Responsive behaviours are recorded. Triggers identified in Care Plans and de-escalation techniques provided as necessary.

Advised all staff to refer to resident's care plans to manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible.

All staff to adhere to Sonas values

Proposed Timescale: 05/07/2017

Theme:

Safe care and support

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

Inspectors observed interactions by two staff members which did not reflect person-centred care of residents.

3. Action Required:

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

These interactions were investigated as per company policy. All staff completed elder abuse training. All staff promote independence of residents by providing care using positive connective approaches.

All staff to adhere to Sonas Company Core values.

All staff will receive additional training in communication and person centred care.

Arrangements in place for additional staff supervision.

Proposed Timescale: 05/07/2017

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

A communication policy was in place but required improvement to inform the communication needs of residents with dementia.

4. Action Required:

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

Daily ongoing supervision of communication of staff with residents will be completed by management staff. QUIS assessment will be completed regularly and staff will be given continuous feedback on how they communication with residents.

Additional Staff training will provide guidance to staff on methods of communication and standard required.

Proposed Timescale: 01/08/2017

Theme:

Person-centred care and support

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

Residents with dementia did not consistently have opportunities to participate in meaningful activities in line with their capabilities, interests and preferences.

5. Action Required:

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

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

All residents will be given every opportunity to participate in activities to meet their needs. Activities are reorganised to ensure that Group and individual activities meet all the complex needs of residents.

Care plans of residents of "Residents with dementia" have been reviewed and all have suitable group and individual activities in which they can participate if they so choose.

Proposed Timescale: 05/07/2017

Outcome 05: Suitable Staffing

Theme:

Workforce

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

The number of staff on duty on the day of the inspection was not sufficient to appropriately supervise residents or meet the assessed needs of all residents.

6. Action Required:

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

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

Staffing levels vary with number of resident's and their dependency. We have reallocated some HCA staff to ensure that all areas are now appropriately supervised. This new arrangement is reviewed daily by management staff in consultations with Nurses and HCAs.

Proposed Timescale: 05/07/2017

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

The layout and space available in one communal sitting/dining room did not meet residents' needs.

While there was storage areas for residents' equipment, some residents' equipment was inappropriately stored in the sensory room in the centre.

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

Some floor surfaces on circulating corridors were uneven.

7. Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

Mal odour in storage room rectified, floor surface in corridor is risk assessed and repaired.

Communal sitting / dining area is reviewed and rearranged to accommodate resident's needs.

Additional storage is now available for all equipment.

Proposed Timescale: 05/07/2017

Outcome 08: Governance and Management

Theme:

Governance, Leadership and Management

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

The monitoring system in place did not ensure that appropriate staffing resources were provided to ensure residents' needs were effectively met.

8. Action Required:

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

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

A schedule of audits is in place. Findings reviewed, trends are identified and appropriate corrective actions taken. Issues identified are discussed with staff at staff meetings, handovers etc and adherence for compliance with corrective actions closely monitored by management staff.

Annual Appraisal completed with all staff.
The requisite support and supervision is in place for all staff. All staff receive regular feedback on their performance by management staff

Proposed Timescale: 05/07/2017