

# eDeposit Ireland

## Sonas Nursing Home, Cloghanboy, Ballymahon Road, Athlone, Westmeath.

Item Type	report
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**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Sonas Nursing Home
<b>Centre ID:</b>	OSV-0000097
<b>Centre address:</b>	Cloghanboy, Ballymahon Road, Athlone, Westmeath.
<b>Telephone number:</b>	090 647 9568
<b>Email address:</b>	athlone@sonas.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Sonas Nursing Homes Management Co. Limited
<b>Provider Nominee:</b>	Seamus Crawley
<b>Lead inspector:</b>	Sonia McCague
<b>Support inspector(s):</b>	Siobhan Kennedy
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	53
<b>Number of vacancies on the date of inspection:</b>	3

## About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

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.

Regulation has two aspects:

- Registration: 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.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

**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 Quality 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 following receipt of unsolicited information. This monitoring inspection was un-announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

From: 04 March 2016 10:30 To: 04 March 2016 18:00

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 14: End of Life Care	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Moderate

**Summary of findings from this inspection**

This inspection was triggered and unannounced following receipt of unsolicited information by the Health Information and Quality Authority (HIQA) that outlined concerns in relation to the management of care, communications and end of life arrangements.

This inspection took place over one day and was focused on specific regulations within the outcomes reported following the information received. Therefore, some outcomes reported on were not examined in full at this time as this was a focused inspection.

The previous inspection of this centre on 03 September 2014 focused on end of life care and food and nutrition. The failings reported had been addressed specific to:

- documentation of clinical audits
- staff acknowledgment of having read specific policies and completed training in administration of sub-cutaneous and thickened fluids
- provision of bereavement arrangements and suitable facilities for relatives at a resident’s end of life.

However, the regulatory action in relation to the requirement to inform the family of a resident approaching end of life and of their condition had not been consistently

demonstrated or reported in practice. This action is restated for address.

On arrival to the centre, inspectors met with the person in charge and other persons participating in the management of the centre who were informed of the purpose of the inspection.

Inspectors met and spoke with residents and staff during this inspection. Residents who spoke with inspectors expressed satisfaction with the care and services provided and were complimentary of the staff group.

As a result of this inspection, some issues of concern highlighted within the unsolicited information received were substantiated resulting in non compliances with the Health Act 2007.

Non compliances were found in relation to resident assessments and care planning, visitors' records, communication and end of life arrangements, clinical recording practices and decision making processes. An annual review of the quality and safety of care delivered to residents had not been completed for the past two years.

Improvements were also required in relation to fire safety arrangements and staff training.

Findings and areas for improvement are outlined in the body of this report and in the action plan at the end for response.

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 Quality Standards for Residential Care Settings for Older People in Ireland.

***Outcome 02: Governance and Management***

*The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.*

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The inspectors met with the person in charge and deputy, the staff team and residents during the course of the inspection. The inspectors found adequate resources available and a clearly defined management structure in place.

Management arrangements and monitoring systems were in place to review the quality of care delivered to residents and inform improvements. A report on the quality and safety of care delivered to residents in the designated centre for 2013 had been completed. However, an annual review of the quality and safety of care delivered to residents in the designated centre for 2014 and 2015 was not available or completed at the time of this inspection.

**Judgment:**

Non Compliant - Moderate

***Outcome 05: Documentation to be kept at a designated centre***

*The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 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 2013.*

**Theme:**

Governance, Leadership and Management

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

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

This outcome was not examined in full on this focused inspection. However, improvements were required in areas examined.

While records required under regulation 21 were available, not all records were examined and in those inspected some improvements were required as follows:

- a register or record of any occasion on which restraint was used, the resident to whom it was applied, the reason for its use, the interventions tried to manage the behaviour, the nature of the restraint and its duration was not maintained as required in schedule 3(4)(g)
- a sufficient and complete record of the name, address and telephone number of the resident's next of kin or of any person authorised to act on their behalf was not sufficiently maintained as required in schedule 3(3)(b)
- a comprehensive nursing record of all communications in relation to each resident by the nurse on duty in accordance with any relevant professional guidelines had not been sufficiently maintained as required in schedule 3(4)(c)
- a record of all visitors to the designated centre, including the names of visitors as required in schedule 4 (12) had not been maintained as required in regulation 21 (4)

**Judgment:**

Non Compliant - Moderate

***Outcome 07: Safeguarding and Safety***

***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. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.***

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

Measures to protect residents being harmed or suffering abuse were described and supporting policies and procedures were in place.

Staff knew what constituted abuse and described what to do in the event of an allegation, suspicion or disclosure of abuse, including who to report any incidents to.

The inspectors were informed there were no active incidents, allegations, or suspicions of abuse under investigation.

From a review of the staff training records the inspectors found that training in relation to the detection and prevention of and responses to abuse was provided to staff.

A policy was available in relation to managing behaviours that challenged. There were no reported incidents where residents' behaviours challenged staff.

A policy was available in relation to the use of restraint. Measures of restraint such as bedrails that restricts the freedom of residents' movement were observed in practice and in use. However, the use of restraints had not been reported or notified to the Authority, as required.

In a sample of resident records reviewed and from discussions with staff and residents it was evident that consultation with residents and or representatives took place in relation to restraint measures used. Restraints such as bedrails were seen in use by up to 10 residents and a lap belt was used by one resident. However, a register of restraints used or in use was not maintained to demonstrate these devices were the least restrictive and or that alternatives had been considered to promote a restraint free environment in line with the national policy guidelines.

**Judgment:**

Non Compliant - Moderate

***Outcome 08: Health and Safety and Risk Management***

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

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

This outcome was not examined in full on this focused inspection.

A system to monitor clinical outcomes was in place which provided an opportunity for learning and improvement. Arrangements were in place for reviewing, investigating and learning from incidents or adverse events involving residents. Clinical audits were maintained to achieve an overall reduction of likely incidents and possible adverse events.

Practices and procedures were in place in relation to the prevention and control of healthcare associated infections.

Measures were in place to prevent accidents in the centre and within the grounds. A fire safety register and associated records were maintained and precautions against the risk of fire were in place. Service records confirmed that the fire alarm system and fire safety equipment including emergency lighting and extinguishers were serviced appropriately and serviced on a regular basis.

However, all fire doors or panels had not been provided with a self closer magnetic release device to ensure sufficient compartmentalisation in the event of an alarm or fire. Additionally, fire doors fitted with magnetic releases were seen held open by wedges that would prevent them from closing and operating as intended in the event of a fire alarm.

**Judgment:**  
Non Compliant - Moderate

***Outcome 10: Notification of Incidents***  
***A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.***

**Theme:**  
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**  
No actions were required from the previous inspection.

**Findings:**  
All notifications under regulation 31 and as outlined in schedule 4 of regulation 21, had not been reported to the Authority, as required.

Any serious injury where a resident required immediate medical and or hospital treatment as outlined in schedule 4 (7) (1) and any occasion when restraint was used as outlined in schedule 4 (7) (1) (f) had not been notified to the Chief Inspector, as required.

**Judgment:**  
Non Compliant - Moderate

***Outcome 11: Health and Social Care Needs***  
***Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. 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.***

**Theme:**

Effective care and support

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

No actions were required from the previous inspection.

**Findings:**

This outcome was not examined in full on this focused inspection.

On a review of resident records available, gaps were found within the assessment, planning and evaluation of care provided. In a sample of resident records reviewed and discussed with staff, the inspectors found that the assessments and clinical care did not consistently accord with evidence based practice.

A comprehensive assessment to include all the support needs of each resident had not been sufficiently maintained to ensure their needs were sufficiently identified or met.

Residents care plans had not been completed following identified needs such as pain management, wound management and elimination needs to ensure adequate arrangements were available, provided and sufficiently organised to meet their needs. Improvements were also required in relation to the end of life care plans maintained to ensure resident's rights to communicate freely were respected.

The care plans reviewed were generic in nature and not sufficiently detailed or completed to inform an appropriate evaluation or review of care provided or required. There was little evidence to demonstrate that the care plans available had been completed after consultation with the resident concerned and where appropriate that resident's family.

There was the lack of evidence found to demonstrate that residents' care plans were available to the resident concerned and with their consent or where appropriate, made available or known to their family. Decisions made on behalf of residents and or decision making processes maintained required review and improvement. Significant information such as a resident's power of attorney, ward of court status or their living will was incomplete in the core assessment details of the sample reviewed.

A high standard of evidence based nursing care and clinical recording in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais was not consistently maintained. Gaps in dates, signatures, words and incomplete clinical records were evidenced in the sample of documents and records reviewed. The full names and titles of those involved in residents care and welfare decisions had not been consistently maintained. The term 'family' was seen recorded without sufficient information to stipulate who was involved. Therefore, some records were not factual and based on summation.

**Judgment:**

Non Compliant - Moderate

***Outcome 14: End of Life Care***

***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.***

**Theme:**

Person-centred care and support

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

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

The failings reported from the previous inspection in relation to end of life were followed up on this inspection.

The requirement specific to the provision of suitable facilities for relatives at the end of a resident's life had been addressed satisfactorily.

Audits following the death of residents were available and maintained to inform improvements. Information contained within the record of residents who had died in 2015 showed that 47% of relatives or next of kin were present with residents' at the end of their life (eight of the 17 residents). However, based on the records maintained and information received improvement was required.

The family and friends of each resident approaching end of life had not been consistently informed of the resident's condition, with the residents consent. This requirement is restated in this action plan.

**Judgment:**

Non Compliant - Moderate

***Outcome 18: Suitable Staffing***

***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. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.***

**Theme:**

Workforce

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

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

This outcome was not examined in full as this was a focused inspection.

A record of resident dependency levels, staff rosters with staffing levels and training programmes were maintained and monitored on a regular basis to inform staffing arrangements.

Staffing levels and skill mix at time of this inspection were adequate to meet the needs of residents.

A programme of training was reported. However, based on the inspection findings, training specific to recording clinical practice, restraint, communications, decision making and consent was required along with improved supervision arrangements.

Recruitment procedures were described as in place. However, the policy, practices and requirements of schedule 2 were not examined on this inspection.

The inspectors were informed there were no people involved on a voluntary basis within the centre at this time.

**Judgment:**

Non Compliant - Moderate

**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:***

Sonia McCague  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Action Plan

### Provider's response to inspection report<sup>1</sup>

Centre name:	Sonas Nursing Home
Centre ID:	OSV-0000097
Date of inspection:	04/03/2016
Date of response:	05/05/2016

### 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 02: Governance and Management

#### Theme:

Governance, Leadership and Management

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

An annual review of the quality and safety of care delivered to residents in the designated centre for 2014 and 2015 was not available or completed at the time of this inspection.

#### 1. Action Required:

Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that

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

such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

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

23d Report for 2015 completed and sent on 27th April 2016 as attachment 1

Proposed Timescale: Completed

**Proposed Timescale:** 06/05/2016

**Outcome 05: Documentation to be kept at a designated centre**

**Theme:**

Governance, Leadership and Management

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

Records to be maintained required improvement as follows:

- a register or record of any occasion on which restraint was used, the resident to whom it was applied, the reason for its use, the interventions tried to manage the behaviour, the nature of the restraint and its duration was not maintained as required in schedule 3(4)(g)
- a sufficient and complete record of the name, address and telephone number of the resident's next of kin or of any person authorised to act on their behalf was not sufficiently maintained as required in schedule 3(3)(b)
- a comprehensive nursing record of all communications in relation to each resident by the nurse on duty in accordance with any relevant professional guidelines had not been sufficiently maintained as required in schedule 3(4)(c)
- a record of all visitors to the designated centre, including the names of visitors as required in schedule 4 (12) had not been maintained as required in regulation 21 (4)

**2. Action Required:**

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

• A register or record of any occasion on which restraint is used, the resident to whom it is applied, the reason for its use, the interventions tried to manage the behaviour, the nature of the restraint and its duration is maintained as required in schedule 3(4) (g). Currently we have no devices that can be classified as "restraint" as defined by the Department of Health "Working Towards a Restraint Free Environment in Nursing Homes" or the Health Act 2007. The equipment used is to promote the independence, comfort or safety of a resident.

• Currently any devices in use have been identified to enable resident's safety and wellbeing. In light of recent inspection outcomes we are reviewing our policies and

procedures to ensure compliance with Schedule 3 (4)(g) as defined by the Department of Health 'Working Towards a Restraint Free Environment' in Nursing Homes.

Timescale: 3 Months

- A record of the name, address and telephone number of the resident's next of kin or of any person authorised to act on their behalf is maintained in residents core details. We are currently reviewing our documentation to include names of others who would like to be contacted if there is a change in circumstances.

- Four monthly audits in place to ensure that all records are complete to meet the needs of each resident.

Timescale: Immediate

- A comprehensive assessment is completed on admission, and care plans are within 48hrs in consultation with residents and/or next of kin. Training has been arranged for all nursing staff to include clinical recording and documentation.

- Four monthly audits in place to ensure that all records are complete to meet the needs of each resident.

Timescale: Immediate

Documentation on clinical care training has been scheduled for 6th and 19th May 2016 for all Nursing Staff

- Visitors records are now retained as required in regulation 21 (4).

**Proposed Timescale:** 29/05/2016

## **Outcome 07: Safeguarding and Safety**

### **Theme:**

Safe care and support

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

Restraints such as bedrails were seen in use by up to 10 residents and a lap belt was used by one resident.

Evidence to demonstrate these devices were the least restrictive and that alternatives had been considered towards a restraint free environment in line with the national policy guidelines was not maintained.

### **3. Action Required:**

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

Currently any devices in use have been identified to enable resident's safety and wellbeing. In light of recent inspection outcomes we are reviewing our policies, procedures, and documentation to ensure compliance with schedule3 (4)(g) as defined by the Department of Health 'Working Towards a Restraint Free Environment' in Nursing Homes'.

**Proposed Timescale:** 30/07/2016

**Outcome 08: Health and Safety and Risk Management**

**Theme:**

Safe care and support

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

All fire doors or panels had not been provided with a self closer magnetic release device to ensure sufficient compartmentalisation in the event of an alarm or fire.

Fire doors fitted with magnetic releases were seen held open by wedges that would prevent them from closing and operating as intended in the event of a fire alarm

**4. Action Required:**

Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

1. Fire door that is fitted with self-closing releases is now repaired.
2. Wedges have been removed from identified doors.
3. Fire doors are now checked on a daily basis.
4. Fire doors and panels that require self-closing magnetic release have been identified and there is an action plan in place.

Proposed Timescale: 1,2,3 Immediate. 4. Six Months

**Proposed Timescale:** 06/05/2016

**Outcome 10: Notification of Incidents**

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement**

**in the following respect:**

Any serious injury where a resident required immediate medical and or hospital treatment as outlined in schedule 4 (7) (1) had not been notified to the Chief Inspector, as required.

**5. Action Required:**

Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

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

The Chief Inspector will be notified within 3 days, of any resident who requires medical or hospital treatment following a serious injury.

**Proposed Timescale:** 06/05/2016

**Theme:**

Safe care and support

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

Any occasion when restraint was used as outlined in schedule 4 (7) (1) (f) had not been notified to the Chief Inspector, as required.

**6. Action Required:**

Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

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

The quarterly returns will include any occasion restraint is used.

**Proposed Timescale:** 06/05/2016

**Outcome 11: Health and Social Care Needs**

**Theme:**

Effective care and support

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

A comprehensive assessment to include all the support needs of each resident had not been sufficiently maintained to ensure their needs were sufficiently identified or met.

**7. Action Required:**

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of

a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

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

. A pre admission assessment is carried out on all potential residents prior to admission.

•A comprehensive assessment is completed on admission, and care plans completed within 48hrs in consultation with residents and/or next of kin .

•Four monthly audits in place to ensure that all records are complete to meet the needs of each resident.

**Proposed Timescale: 06/05/2016**

**Theme:**

Effective care and support

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

Residents care plans had not been completed following identified needs to ensure adequate arrangements were available and sufficiently organised to meet their needs and respect their rights to communicate freely.

**8. 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:**

•A comprehensive assessment is completed on admission, and care plans completed within 48hrs in consultation with residents or next of kin .

•Care Plans have been revised to include evidence that resident's /next of kin have been communicated with and involved in the plan of care.

**Proposed Timescale: 06/05/2016**

**Theme:**

Effective care and support

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

The care plans reviewed were not sufficiently detailed or completed to inform an appropriate evaluation or review of care provided or required.

There was little evidence to demonstrate that the care plans available had been completed after consultation with the resident concerned and where appropriate that

resident's family.

**9. Action Required:**

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

The care plans are updated and amended, when necessary, on a 4 monthly basis, or sooner if change in resident's condition .

- Four monthly audits in place to ensure that all records are complete to meet the needs of each resident.
- Care Plans have been revised to include evidence that residents /next of kin have been communicated with and involved in the plan of care.
- Training has been arranged for all nursing staff to include clinical recording and documentation, 6th &19th May.

Proposed Timescale: Immediate & 29th May

**Proposed Timescale:** 29/05/2016

**Theme:**

Effective care and support

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

There was the lack of evidence found to demonstrate that residents' care plans were available to the resident concerned and with their consent or where appropriate, made available or known to their family.

Decisions made on behalf of residents and or decision making processes maintained required review and improvement. Significant information such as a resident's power of attorney, ward of court status or their living will was incomplete in the core assessment details of the sample reviewed.

**10. Action Required:**

Under Regulation 05(5) you are required to: Make the care plan, or revised care plan, prepared under Regulation 5 available to the resident concerned and, with the consent of that resident or where the person-in-charge considers it appropriate, to his or her family.

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

- Care Plans have been revised to include evidence that residents /next of kin have been communicated with and involved in the plan of care.
- Care plans are reviewed on a four monthly basis in in consultation with resident, next of kin if applicable, and other relevant members of the multidisciplinary team.
- Four monthly audits in place to ensure that all records are complete to meet the needs of each resident.
- Training has been arranged for all nursing staff to include clinical recording and documentation 6 &19th May.

**Proposed Timescale:** 29/05/2016

**Theme:**

Effective care and support

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

A high standard of evidence based nursing care and clinical recording in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais was not consistently maintained.

Gaps in dates, signatures, words and incomplete clinical records were evidenced in the sample of documents and records reviewed.

The full names and titles of those involved in residents care and welfare decisions had not been consistently maintained.

The term 'family' was seen recorded without sufficient information to stipulate who was involved. Therefore, some records were not factual and based on summation.

**11. Action Required:**

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

- Training in relation to documentation and clinical recording has been arranged for 6th and 19th May 2016.
- Four monthly audits in place to ensure that all records are complete to meet the needs of each resident.

Proposed Timescale: 19/05/2016

#### Outcome 14: End of Life Care

**Theme:**

Person-centred care and support

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

The family and friends of each resident approaching end of life had not been consistently informed of the resident's condition, with the residents consent.

**12. Action Required:**

Under Regulation 13(1)(c) you are required to: Inform the family and friends of the resident approaching end of life of the resident's condition, with the resident's consent. Permit them to be with the resident and provide suitable facilities for them.

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

- End of Life Care Plans have been revised to include evidence that residents /next of kin have been communicated with and involved in the plan of care, and also names of any other parties with the residents consent if possible, that need to be contacted when any changes occur in residents' condition.

- We do permit family and friends of the resident approaching end of life to be with the resident and we provide suitable facilities for them. We endeavour to keep family and friends informed of any deterioration in their relative's condition, in exceptional circumstance this may not be possible.

- Training in relation to documentation and clinical recording has been arranged for 6th and 19th May 2016.

Proposed Timescale: Immediate & 29th May 2016

Proposed Timescale: 29/05/2016

#### Outcome 18: Suitable Staffing

**Theme:**

Workforce

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

Based on the inspection findings, training specific to clinical practice recording, restraint, communications, decision making processes and consent was required along with improved supervision arrangements.

**13. Action Required:**

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

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

- All staff on induction receives information on restraint and the Sonas Restraint Policy and Procedure, in line with the National Policy on restraint. Training is given as identified.

- Training has been arranged for all nursing staff to include clinical practice recording, communications, decision making processes and consent on 6th and 19th May 2016

**Proposed Timescale:** 19/05/2016