Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Sonas Nursing Home Riverview
Name of provider:	Storey Broe Nursing Service Limited
Address of centre:	Morrison Terrace, Mullauns, Ballina, Mayo
Type of inspection:	Unannounced
Date of inspection:	26 January 2022
Centre ID:	OSV-0005504
Fieldwork ID:	MON-0033563

About the designated centre

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

Sonas Nursing Home, Riverview is a modern building that opened in 2017. It is registered to provide care for 53 male and female residents who require long-term, continuing, convalescent or respite care. Care is primarily provided to people over 65 years with low to maximum dependency care needs. The centre is located near the river Moy in Ballina and is a short drive from the train station, shops and business premises in the town. Residents' accommodation is provided in five double and 43 single rooms. Residents have access to appropriately spacious communal sitting and dining areas, a visitors' room and an enclosed courtyard garden that can be accessed from several points around the building. The centre has good levels of natural light and windows throughout enable residents to see the outdoors when seated in armchairs. Catering, laundry and staff areas are also located within the building. The aim of the centre as described in the statement of purpose is to provide a residential setting where residents are cared for, supported and valued within the care environment that promotes the health and well-being of residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	46

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 26 January 2022	10:30hrs to 19:00hrs	Leanne Crowe	Lead
Wednesday 26 January 2022	10:30hrs to 19:00hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

This inspection took place during an outbreak of COVID-19 in the centre. While this limited the time inspectors could spend observing and speaking with residents on the day of the inspection, the inspectors were able to carry out a walkabout of the designated centre and spoke with staff and residents in a safe manner.

When inspectors arrived at the centre they were guided through infection prevention and control measures necessary on entering the designated centre. These processes were comprehensive and included a signing-in process, hand hygiene, the wearing of face masks, and checking for signs of COVID-19.

The centre had been divided into two zones in response to the COVID-19 outbreak. A red zone, accommodating residents who had tested positive for COVID-19 and residents who had remained undetected but were already living in this area, and a green zone, accommodating residents who had remained undetected for COVID-19. The residents in the red zone who had tested positive were encouraged by staff to remain in isolation in their bedrooms and were attended to by a dedicated staff team who adhered to the current infection prevention and control guidelines. A dedicated communal area was available in the red zone to support residents who remained undetected to socialise and mobilise safely. A small number of residents were observed using this room during the inspection, with support and supervision from staff.

Within the green zone, residents were facilitated to spend their days in their bedrooms or in communal areas of their choosing. Inspectors found that staff interacted with residents in a respectful and dignified manner. Residents were seen to be at ease, looking comfortable and relaxed in the company of staff. Residents were referred to by their preferred names and it was clear that staff knew the residents well. The small number of residents spoken with told inspectors that staff were kind to them and that they felt well looked after.

Inspectors observed that residents' bedrooms were personalised with possessions that were meaningful to them and reflected their life experiences. There was adequate storage available in bedrooms. Each resident had ensuite sanitary facilities.

The centre was observed to be clean and tidy throughout the inspection. Staff were observed appropriately using PPE (personal protective equipment) and adhering to hand hygiene practices when required.

The inspectors did not meet with any visitors in the centre on the day of the inspection. The inspectors were informed that compassionate visits were facilitated at all times throughout the outbreak, and that staff assisted residents with video and telephone calls to maintain contact with families. A messaging system was in place to ensure that families or residents' representatives were kept up-to-date with what

was going on in the centre and any change in a resident's medical condition.

The next two sections of the report will discuss the governance and management of the centre and the quality and safety of care. The findings will be reported under the relevant regulations in each section.

Capacity and capability

This was an unannounced risk inspection conducted by inspectors of social services to assess compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). Inspectors found that while some improvements had been made to the overall governance and management of the centre since the previous inspection, the organisational structure of the centre was unclear and lacked the support of suitably qualified and experienced staff.

As part of this inspection, inspectors sought assurances that appropriate governance and management arrangements were in place, in line with the requirements under regulations 14 and 23. The registered provider for Sonas Nursing Home Riverview is Storey Broe Nursing Service Limited. At the time of the inspection, the governance structure consisted of an executive director that represented the registered provider, a quality and governance co-ordinator, a quality manager and the person in charge. The provider had notified the Chief Inspector of the temporary absence of the person in charge for the designated centre, which was to commence on 1 December 2021. The assistant person in charge post in the centre became vacant in January 2022. While arrangements were made to fill the person in charge's role, at the time of the inspection the assistant person in charge position and the clinical nurse manager position were vacant. Inspectors were informed at the inspection that recruitment was ongoing to fill the clinical nurse manager role and that the registered provider had developed a governance roster to supervise and support this person. However, this roster demonstrated that a designated person was only providing on site support on average of three days per week. Additionally, the inspectors found that the person proposed to fill the person in charge role did not meet the criteria set out by the regulations. As a result, inspectors were concerned that these deficits were negatively impacting on the registered provider's ability to effectively govern the designated centre.

There were sufficient staff on duty on the day of inspection, with staff being divided into teams dedicated to the red and green zones respectively. To support this, additional staff had been rostered, some of which were agency staff. Inspectors noted that since the previous inspection, the number of staff on night duty had been increased.

Training records were provided to inspectors and these indicated that all but a small number of staff had received up-to-date training in fire safety, safeguarding of residents and moving and handling practices. The majority of staff had also recently

completed training in areas such as infection prevention and control, dementia care and restrictive practices. A number of nurses had also completed basic life support training.

A sample of staff files were reviewed and it was found that they contained all of the information and documentation required by Schedule 2 of the regulations.

There was an up-to-date complaints policy and procedure in place that reflected the requirements under regulation 34. A summary of this procedure was displayed prominently throughout the centre.

Inspectors also followed-up on the actions taken by the provider to address the non-compliances found on the last inspection in April 2021. The inspectors found that th majority of these actions had been addressed satisfactorily, with further improvements required in relation to risk management, records and the management of complaints.

Regulation 14: Persons in charge

Inspectors found that the person employed for the role of person in charge did not meet the requirements of the regulations.

Judgment: Not compliant

Regulation 15: Staffing

On the day of the inspection, there were sufficient staff on duty in both the red and green zones. Management explained to inspectors that the staff on duty on the day of the inspection exceeded the usual staff complement in order to support the management of the COVID-19 outbreak. An action from the previous inspection had been addressed, there were a minimum of two nurses rostered for night duty and staffing levels had been reviewed to ensure they met the assessed needs of residents.

Judgment: Compliant

Regulation 16: Training and staff development

An ongoing training programme that included all required mandatory training was in place for all grades of staff. Records indicated that all staff were up to date in moving and handling practices. The majority of staff had also recently completed

training in fire safety, infection prevention and control and the safeguarding of residents. A total of nine staff required refresher training in one of these respective areas but completion of this had been impacted by the ongoing outbreak of COVID-19. Management were aware of this and were in the process of addressing it at the time of the inspection. The majority of staff had also completed other training to support them in providing care to residents, including restrictive practices, dementia care and responsive behaviours.

A number of staff, including eight nurses, had also completed training in basic life support.

Judgment: Compliant

Regulation 21: Records

Accidents and incidents in the centre were poorly documented. Incident investigations were not documented or reviewed. This meant that any potential learning from an incident was not identified, and therefore, could not be used to improve the quality of the service delivered.

There were two separate rosters in operation in the centre, one relating to permanent staff and a second relating to agency staff. Since the last inspection, multi task attendants were now identified clearly on the centre's rosters. However, staff rostered to support the activity co-ordinator in their duties were not clearly identified and therefore the documents required further review to ensure they accurately reflect the staff on duty.

Judgment: Substantially compliant

Regulation 23: Governance and management

A number of actions had been identified at the previous inspection, which inspectors followed up at this inspection. Inspectors found that while a number of these had been addressed, others required further improvement to address the non-compliances identified at this inspection. For example:

- While a schedule of auditing was in place, inspectors identified incomplete audits lacking identification of areas of improvement. For example, only one falls management audit was available for review. This audit was incomplete as the information gathered had not been analysed and therefore, no quality improvement plan could be developed
- Poorly documented risk assessments lacked the detail required to communicate how a risk was controlled

- Adverse incidents were poorly documented and failed to identify quality improvement plans to prevent recurrence of these incidents
- There was poor oversight of residents survey responses. For example, no action plan had been developed to address the issues raised by residents in a survey completed on 17 January 2022.

An annual review for 2021 was complete at the time of the inspection and included an action plan for 2022.

Judgment: Not compliant

Regulation 34: Complaints procedure

Inspectors found evidence that some complaints were well documented and managed in line with the centre's own policy. However, a number of complaints, including a complaint made by a resident during a residents' meeting, had not been properly investigated and managed. There was a system of audit in place to review complaints, however, a review of this audit found that the detail documented was limited and could not be used to identify a quality improvement plan.

Judgment: Substantially compliant

Quality and safety

Overall, inspectors found that care was delivered to residents to a satisfactory standard. Improvement was found in the documentation of resident assessment and care planning. There was a system in place to ensure that risks regarding fire safety were appropriately managed. Inspectors also found an improvement in relation to the protection of residents rights.

As mentioned earlier in the report, there was an outbreak of COVID-19 in the centre on the day of the inspection. Residents who had tested positive for COVID-19 were monitored closely and prompt action was taken if their condition deteriorated. While visiting restrictions were in place at the time of the inspection, any exceptions such as window visits and those on compassionate grounds were facilitated in line with the most recent Health Protection and Surveillance Centre (HPSC) guidelines.

A system of risk management was in place. While appropriate risks had been identified and included onto the risk register, improvement was required to ensure that the controls in place to manage the risk were clearly documented. There was a preventive maintenance schedule of fire safety equipment, the fire alarm and emergency lighting in accordance with the recommended frequency. A review of the non-compliances from the previous inspection in April 2021 found that issues

relating to regulation 28, fire precautions had been addressed.

A residents' council meeting had been held in January 22, and minutes of this meeting was available for review. A further meeting was scheduled for February 2022. During the outbreak, a system for messaging all families or representatives of residents was developed, and there was evidence that this was used regularly to provide assurances and disseminate key information about the outbreak and the residents' well-being.

Regulation 11: Visits

Visiting was not occurring at the time of the inspection due to the outbreak of COVID-19. However, inspectors were informed that there were arrangements in place to facilitate window visits and visiting on compassionate grounds. Residents were supported to maintain contact with their loved ones through phone and video calls during this time.

Judgment: Compliant

Regulation 26: Risk management

A review of the risk management policy found that it was up-to-date and reflected the requirements under regulation 26. A live risk register had recently been introduced and was available to all staff. While some on-going risks were identified in the register, the detail in relation to the controls in place were poor and did not identify the action taken to control the risk. For example, an appropriately identified risk in relation to changes in staffing levels as a result of the COVID-19 outbreak did not contain any detail in relation to how staff would be managed if this risk occurred. An action relating to this is featured under regulation 23, governance and management.

Judgment: Compliant

Regulation 28: Fire precautions

There was evidence to demonstrate that fire safety equipment was regularly assessed and serviced.

A number of actions had been completed since the previous inspection. These are set out below.

Fire safety drills were carried out on a regular basis, and records indicated that recent drills simulated evacuations of the centre's largest fire compartment and areas containing residents with the highest assessed needs. Night duty staffing levels had been reflected during these drills.

Residents' personal emergency evacuation plans (PEEPs) had been reviewed since the previous inspection and now contained the most recent date of review, as well as other pertinent information about the residents' needs.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

All residents had an appropriate schedule of nursing assessments in place. Examples of these assessments included a residents risk of falls, malnutrition and risk of social isolation. Each resident also had an overall dependency assessment completed. These assessments informed the development of a detailed, person-centred care plan which guided staff to deliver consistent and appropriate standard of care. This issue was addressed from the last inspection.

Judgment: Compliant

Regulation 6: Health care

Residents had appropriate access to a doctor of their choice. Residents were also supported by a team of allied health care professional services such as physiotherapy, dietitian, speech and language therapy and chiropody. A review of residents notes found that residents were appropriately referred to these services and recommendation made were incorporated into the residents care plans.

Judgment: Compliant

Regulation 9: Residents' rights

Residents rights were found to be respected in the centre. There was a robust schedule of activities in place and this was well communicated to residents through residents meetings and displayed in prominent areas around the centre.

Access to advocacy services was facilitated and promoted. A review of a number of residents with complex social care needs found that their needs were assessed and appropriate interventions including referral to advocacy services had been

completed. This is a completed action from the last inspection.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 26: Risk management	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Sonas Nursing Home Riverview OSV-0005504

Inspection ID: MON-0033563

Date of inspection: 26/01/2022

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: A person in charge has been appointed. Complete.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: A full review of accidents and incidents has taken place. Complete. The Quality & Safety meeting chaired by the Director of Quality & Governance is scheduled for 19/04/2022. This will facilitate communication and discussion of the findings from all incidents, feedback, audits, inspections etc. with the team. This will enable the sharing of all learning and the agreement of new quality improvement plans. Departmental staff meetings have taken place in the interim. Ongoing & Complete. Education sessions for staff re. the understanding and documentation of incidents, falls and responsive behaviours have been provided by external educators 30/03/2022 & 13/04/2022. There is a plan in place to supervise the application of enhanced knowledge to practice. Ongoing. All staff and their designations and allocations are clearly marked on the roster and this is overseen by the newly appointed office manager and the quality manager. The rosters can also be viewed remotely by the Director of Quality & Governance and the Director of Operations. Complete.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Additional training in auditing has been provided to all PICs, DONs, APICs, CNMs and SSNs in Sonas nursing homes. 10/03/2022. A new triangulation template has also been prepared by the quality team and is now in use. This should ensure that the audit and quality improvement cycle is completed to the required standard. Ongoing.

The risk register has been reviewed and updated further and team discussions re. the content have taken place. Complete.

Education sessions for staff re. the understanding and documentation of adverse incidents have been provided by external educators 30/03/2022 & 13/04/2022. There is a plan in place to supervise the application of enhanced knowledge to practice. Ongoing.

The DON has met with the activities team and reviewed the residents surveys. Action plans have been prepared and are in progress. A further survey will be conducted in quarter 2 of 2022.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
A full review of all records and documents has taken place. Complete.

A new triangulation template has also been prepared by the quality team and is now in use. This should ensure that the audit and quality improvement cycle is completed to the required standard. It will also ensure that there is follow through from all feedback and that this is directed for the appropriate further action and follow up. The quality manager monitors this weekly through the PIC weekly report. A quarterly formal analysis of all feedback is also undertaken by the PIC, DON, quality manager and Director of Quality & Governance. Ongoing.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 14(6)(a)	A person who is employed to be a person in charge on or after the day which is 3 years after the day on which these Regulations come into operation shall have not less than 3 years experience in a management capacity in the health and social care area.	Not Compliant	Orange	07/04/2022
Regulation 14(6)(b)	A person who is employed to be a person in charge on or after the day which is 3 years after the day on which these Regulations come into operation shall have a post registration management qualification in health or a related field.	Not Compliant	Orange	07/04/2022

Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Yellow	07/04/2022
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	13/04/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	13/04/2022
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints	Substantially Compliant	Yellow	07/04/2022

	promptly.			
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	07/04/2022
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.	Substantially Compliant	Yellow	07/04/2022
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully	Substantially Compliant	Yellow	07/04/2022

	and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.			