

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Shannagh Bay Nursing Home
<b>Centre ID:</b>	OSV-0000095
<b>Centre address:</b>	2-3 Fitzwilliam Terrace, Strand Road, Bray, Wicklow.
<b>Telephone number:</b>	01 286 2329
<b>Email address:</b>	info@shannaghbay.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Shannagh Bay Healthcare Limited
<b>Provider Nominee:</b>	Pauline Smith
<b>Lead inspector:</b>	Gary Kiernan
<b>Support inspector(s):</b>	Conor Dennehy;
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	41
<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 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 to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

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

From:	To:
21 October 2014 10:15	21 October 2014 19:00
22 October 2014 10:15	22 October 2014 16:00

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

Outcome 01: Statement of Purpose
Outcome 02: Governance and Management
Outcome 03: Information for residents
Outcome 04: Suitable Person in Charge
Outcome 05: Documentation to be kept at a designated centre
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 10: Notification of Incidents
Outcome 11: Health and Social Care Needs
Outcome 13: Complaints procedures
Outcome 18: Suitable Staffing

**Summary of findings from this inspection**

As part of the monitoring inspection inspectors met with residents, relatives, and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Inspectors were concerned that improvements in the care and welfare of residents had not been maintained to a satisfactory degree since previous inspections, despite assurances given by the provider. There was an unsatisfactory level of compliance with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

There was a failure to ensure that staffing issues were managed through a strong governance and management structure. There was a high turnover of staff and a substantial amount of sick leave with a potential for negative impacts on residents. On the first day of this inspection the number and skill mix of staff was not sufficient to meet the needs of residents. This matter was subsequently addressed on the second day of inspection. There were inadequate deputising arrangements in the

absence of the person in charge.

The arrangements to meet residents' assessed needs were not satisfactory. Some residents were required to wait to go to the toilet, to have their meals and to go back to bed on day one of this inspection. Individual assessments were not updated and care plans were not reviewed when there were significant changes in the residents' conditions. Evidence based nursing practice was not demonstrated in the area of wound management. Satisfactory arrangements were not in place to meet the social care needs of residents.

The system in place to ensure that residents were protected from all forms of financial abuse required review. Other improvements were required in the area of mandatory training for staff, contracts of care and complaints management.

These matters are discussed further in the report and in the Action Plan at the end of the report.

**Section 41(1)(c) of the Health Act 2007. 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.**

**Outcome 01: Statement of Purpose**

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

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

There statement of purpose had not been maintained up to date in accordance with the requirements of the Regulations.

The statement of purpose reflected the services and facilities provided and described the aims, objectives and ethos of the service. It was noted by the inspectors that the statement of purpose was available for reading at designated information points throughout the centre.

**Judgment:**

Non Compliant - Minor

**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:**

There were renewed concerns regarding the adequacy of the governance and management arrangements in place.

Inspectors had particular concerns that sufficient staffing resources were not available to ensure the effective delivery of care. Inspectors were concerned that there was a high staff turnover within the centre and there was a potential for this to have a negative impact on outcomes for residents. It was noted that there were also a high percentage

of sick leave, with 52 days sick days in September alone. The provider and person in charge outlined difficulties in recruiting qualified nursing staff despite having examined a number of options. The provider and person in charge stated that two full time nurses were needed in order to ensure that there would be sufficient nursing staff to provide cover on a continual basis. However inspectors were not satisfied that an appropriate plan had been put in place manage this aspect of staff recruitment and staff retention. An appropriate plan was similarly absent to manage the number of sick days in the centre. As highlighted under outcome 4 and 18 inspectors had concerns regarding staffing arrangements at the time of inspection and observed examples of ineffective delivery of care as a result. There was also a lack of clinical governance as a result of the failure to ensure adequate deputising arrangements in the absence of the person in charge.

Inspectors also reviewed the systems in place to monitor the quality and safety of care and the quality of life of residents on an ongoing basis. Effective systems were not in place. There were some systems in place to monitor the care delivered to residents however, they did not result in learning and improvement. For example the person in charge had carried out a review of care plans and had issued instructions to staff based on findings which showed the need for a number of urgent improvements. However, this process had not brought about the required improvements despite repeated instructions being issued by the person in charge.

The provider and person in charge had worked with outside consultants in order to develop a system of audits to monitor the quality and safety of care. However, at the time of inspection, this system had not been implemented. This matter has been highlighted as an area for improvement at a number of previous inspections. As highlighted under outcome 4, inspectors had concerns about the participation of the person in charge in the governance and management of the centre. Following inspection, the person in charge sent an information update to the Authority indicating that progress had been achieved in this area.

**Judgment:**

Non Compliant - Major

***Outcome 03: Information for residents***

*A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.*

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The contracts of care provided to residents were not satisfactory.

Inspectors read a number of contracts of care which had been agreed and signed with

residents after their admission to the centre. The contracts of care dealt with the services to be provided to the resident for an agreed fee. The fees for some additional services were also highlighted in the contracts.

However the contracts of care did not describe all fees which were charged to the residents. For example, an "Administration Charge" had been recently introduced at the rate of two Euro per day for all residents. This charge had not been agreed with residents as part of their contract of care. Similarly residents were also charged for name tags for clothes and this matter was not dealt with in the contracts.

Inspectors were also concerned that residents were charged for items which their contracts of care indicated were already included in their weekly fee. For example, a fee for bed linen was applied in the case where a double bed sheets were required to be purchased. The contract of care which had been agreed with the resident did not provide for this charge.

**Judgment:**

Non Compliant - Moderate

***Outcome 04: Suitable Person in Charge***

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

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

While the requirements for the role of person in charge were met, with regard to qualifications and experience, there continued to be concerns in this area.

Due to a lack of experienced nursing staff the person in charge was required to undertake a number of nursing duties on a routine basis. For example, she regularly carried out nursing assessments and developed care plans. The roster also showed that the person in charge had been required to cover some nursing shifts. Inspectors were concerned that this was adversely affecting the ability of the person in charge to fully participate in the overall supervision of care and the governance and management of the centre.

The deputising arrangements for the person in charge were not satisfactory. On day one of this inspection the person in charge was on leave. A satisfactory deputising arrangement was not in place. Of the two nurses on duty, one only worked occasionally as a part time staff member and the other staff member was not an experienced member of the staff team. Inspectors found that a lack of clinical leadership on this first day of inspection resulted in negative outcomes for residents as highlighted under outcome 11.

**Judgment:**

Compliant

**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):**

No actions were required from the previous inspection.

**Findings:**

The risk management policy referred to in outcome 8 was not implemented with regard to residents who smoke.

**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:**

The systems in place for protecting residents from financial abuse were not satisfactory. Improvements were also required in the provision of up-to-date training for staff in protection and safeguarding.

Inspectors reviewed the systems in place for protecting residents from forms of financial abuse. Inspectors were not satisfied that the systems in place for charging some fees was in accordance with the centre's own policies and procedures. For example, a large number of residents were routinely charged for physiotherapy, however no record was maintained to indicate if the resident attended the physiotherapy session charged for. In the case of other fees for items such as cigarettes and alcohol a log book recorded



transactions and charges made. In some cases residents signed this record. However, there were gaps in these records and the requirement for two staff signatures was not consistently implemented for residents who could not sign.

There was a policy in place relating to elder abuse with sufficient detail to guide staff on the on the steps to take in the event of an allegation of abuse. Staff interviewed were knowledgeable about identifying abuse, the different forms of abuse and the appropriate actions to be taken in the event of a incident or suspicion of abuse. It was also stressed by staff that issues relating to protection are taken very seriously within the centre and that there would be no issue with reporting any instance of abuse.

However on reviewing the centre's staff training records it was observed by inspectors that five current staff members had not participated in elder abuse training within the required timeframes. It was noted that training days in this area are scheduled to take place in November.

**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:**

Procedures were in place to promote the health and safety of residents, staff and visitors; however, improvements were required.

There was a risk management policy which addressed the risks specified in the Regulations as well as the centre specific procedures in place for the identification and management of risk. The risk management policy required that smoking risk assessments to be carried out, reviewed and updated on a regular basis. However, inspectors noted that some of these smoking assessments had not been updated at the required frequencies. This was of particular concern as it was noted that this procedure had been developed in response to previously very significant incident which had occurred in the centre.

Inspectors observed the supervision arrangements in place for residents who smoked. A smoking room was provided and the inspector observed that smoking aprons and fire blankets were provided in this area. Some residents, who had been assessed as safe to smoke without supervision did so in an area at the front of the building. There was a policy in place which required all other residents to be directly supervised while smoking. Inspectors found that this policy was implemented at the time of inspection.

Inspectors reviewed fire safety procedures and associated records. Fire orders were

prominently displayed and fire exits were unobstructed. The staff members, spoken to by inspectors, were knowledgeable with regard to the procedures to follow in the event of fire. The training records showed that fire safety training had been given to the staff and records were also in place to show that regular fire drills took place on a monthly basis. However, 4 staff members had not attended up-to-date mandatory training in fire safety.

The inspector also reviewed the records with regard to servicing of fire safety and prevention equipment. The records showed that there was servicing by external consultants of the fire detection and alarm system and of fire fighting equipment. Inspectors noted that while recent checks of the fire alarm system and emergency lighting system had taken place, these checks were not being carried out at the required quarterly frequencies. This matter was brought to the attention of the provider and person in charge who undertook to address it. A documented system of in-house checks on fire exits, emergency lighting and the fire detection system was also in place.

Systems were in place for the recording and learning from accidents, incidents and near misses. Records of all accidents were maintained and the form included a section on learning outcomes and interventions to prevent reoccurrence. The records indicated that accidents and incidents were reviewed by the person in charge and discussed with the staff in order to identify any further interventions to prevent reoccurrence.

There was an infection control procedure in place. Nursing staff and care assistants were observed following correct hand hygiene and all staff had access to gloves, hand gels and aprons. Staff members spoken to by inspectors had received training in infection control and were knowledgeable about the procedures to follow to prevent the spread of infection.

The centre had an emergency plan in place which provided information to guide staff on the procedures to follow in the event of evacuation and foreseeable emergencies such as loss of heat and power. The plan provided detailed information with regard to evacuation procedures and alternative accommodation.

The training matrix showed that staff had up-to-date training in moving and handling. In response to findings from the previous inspection, residents' moving and handling assessments had been assessed and instructions for assisting residents to mobilise were available for staff.

**Judgment:**

Non Compliant - Moderate

***Outcome 09: Medication Management***

*Each resident is protected by the designated centre's policies and procedures for medication management.*

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

Inspectors were satisfied that each resident was protected by the designated centre's policies and procedures for medication management.

Having reviewed prescription and administration records, procedures for the storage of medication including those requiring refrigeration and procedures for the management of medications that required strict controls, inspectors were satisfied that appropriate medication management practices were in place guided by a comprehensive policy.

Staff members had received training in medication management and were knowledgeable regarding the appropriate responses in the event that they noticed any medication errors to ensure any discrepancies were rectified immediately. Written evidence was available that three-monthly reviews were carried out.

**Judgment:**

Compliant

**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:**

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

**Judgment:**

Compliant

**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):**

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

**Findings:**

Improvements were required in order to ensure that residents' health and social care needs were consistently met. The required improvements had not been implemented or maintained since the previous inspection.

Inspectors had concerns that residents care needs were not being met. As highlighted under outcome 18, the staffing arrangements on day one of this inspection were not satisfactory to meet residents' needs. Inspectors observed a resident who asked to go to the toilet being told to wait as staff were busy. Another resident who asked to go back to bed was also requested to wait for the same reason. Inspectors also observed a resident who was waiting for an excessive period for the meal to be served. Inspectors spoke to this resident who was upset at the delay. While the resident was eventually served the meal, the resident found that it was cold and it had to be returned to the kitchen to be reheated. On day two of this inspection, when the person in charge was present in the centre, it was found that many of these matters had been addressed.

Inspectors were concerned that residents' healthcare needs were not routinely assessed and care plans had not been updated and reviewed when residents' needs changed. For example, appropriate assessments and care plans had not been put in place for a resident who had returned from a rehabilitation centre with detailed instructions regarding the care of the resident. Inspectors found that staff members were not aware of all these instructions. In the absence of updated care plans there was a potential for inconsistent care delivery and negative outcomes for the resident.

There were other examples where care plans had not been updated in response to residents' changing needs. One resident was receiving end of life care and was being seen by the palliative care team. While this resident had an end of life care plan in place this plan had not been updated further to the previous two visits by the palliative team. On both occasions changes were recommended which should have been incorporated into the end of life care plan. In the case of a resident who had experienced a fall and fracture, the relevant care plans had not been updated to reflect the resident's altered needs and the full range of interventions needed to prevent further reoccurrence. As highlighted under outcome 18, sufficient staff were not present in the main seating areas in order to supervise residents who were at risk of falling.

Inspectors reviewed the procedures and documentation in place for a resident who had two wounds and found that improvements were required. There were gaps in the documentation. The required wound management documentation had not been routinely completed further to each dressing change. There were no measurements or photographs available which would allow close monitoring of each of the wounds. In the case of one of the wounds, the instructions regarding the type of dressing and dressing regime were not included. Therefore inspectors found that wound management was not being carried out in accordance with the centre's own procedures and there was a risk that this could result in inconsistent practice and negative outcomes for the resident.

Inspectors reviewed the care of residents who were losing weight or who were at risk of

poor nutrition and found evidence of satisfactory practice. Regular nutritional assessments were carried out for residents. There was good access to the dietician and speech and language therapist (SALT) where required. Residents were provided with supplements where indicated and food was fortified for some residents. Most residents were weighed regularly. Some residents were not weighed at the frequencies recommended by the dietician and this matter was brought to the attention of the person in charge who undertook to address this.

Inspectors reviewed the procedures in place to monitor and respond to pain. This area had been identified as an area for improvement at the previous inspection. There was evidence of improved practice in this area. Pain monitoring assessments were completed. In most cases nursing staff monitored residents' pain and recorded this in the progress notes. The effectiveness, of pain medication administered, was also recorded.

The previous inspection also identified the management of restraint as an area for improvement. Inspectors found that this matter had been addressed. Staff were aware of the need to reduce or eliminate restraint. Where restraints such as bed rails were in use, the appropriate documentation was in place to demonstrate the considerations of the alternatives and the assessment of the risks.

The arrangements to meet residents social care needs required improvement. Satisfactory arrangements were not in place to consistently assess and meet residents assessed social care needs. This matter has been identified as an area for action at a number of previous inspections. Some social care assessments were not up to date. In cases where care plans had been developed to meet residents' social care needs, these care plans did not contain sufficient detail to inform staff how to meet these needs. At the time of inspection the activities coordinator was involved in supervising the day room for much of the day. As a result she did not have sufficient time to undertake meaningful activities with residents on a group or individual basis. The inspector noted that participation levels in certain activities was quite low, although this situation was improved on day two of inspection when improved staff arrangements were in place.

**Judgment:**

Non Compliant - Major

***Outcome 13: Complaints procedures***

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

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

Practice in relation to complaints management required improvement.

The procedure for complaints was displayed for residents and it clearly identified the

complaints officer. Complainants who were not satisfied with the initial response to their complaint were directed to an independent appeals process. There was a comprehensive centre-specific policy in place which provided clear guidance to staff.

The person in charge and the provider demonstrated a positive attitude towards complaints. However, inspectors noted that a recently received complaint, which raised important issues regarding the care of a resident, had not been managed in accordance with the centre's complaints procedure. While the person in charge had emailed the complainant to provide reassurance that the matters raised had been addressed, the complaints log had not been completed and a record of the investigation carried out was not available for review by inspectors. A record of whether or not the complainant was satisfied with the complaint outcome was not maintained in accordance with the requirements of the Regulations.

**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):**

No actions were required from the previous inspection.

**Findings:**

The staffing arrangements were not satisfactory to meet the needs of residents.

The number and skill mix of staff in the centre was not satisfactory. As stated under outcome 2, there was an insufficient number of full time nurses, who were appropriately qualified and experienced, to provide ongoing cover. In accordance with the assessed needs of the residents two nurses were required to cover both the day and night shifts. However, inspectors noted that for a period of at least four weeks prior to inspection only one nurse had been on duty at night time. While this matter had been addressed at the time of this inspection, inspectors were concerned that this situation had developed.

On the day one of the inspection, the activities coordinator was responsible for supervising 24 residents in the main sitting room. Other residents, who required regular assistance, were seated in the adjacent hallway and conservatory. A number of these residents had complex needs associated with dementia, paraplegia and other conditions. A number, who were at a high risk of falling, were seen attempting to leave their chairs

and walk without assistance. While supervising these residents the activities coordinator was also attempting to engage the residents with exercise, games and quizzes. The activities coordinator was also called upon to leave the room for a number of brief periods which resulted in this room being unsupervised at these times. Inspectors were concerned that residents were not appropriately supervised while in this room and the staffing arrangements did not provide for the meeting of their care needs in a timely way as discussed under outcome 11. Inspectors noted that a large number of care assistants on duty on day one of inspection were relatively newly employed and relied on the support of their more senior colleagues in carrying out routine tasks. This was found to have an effect on the timely delivery of care.

A sample of staff files was reviewed and the inspector noted that the required documentation was in place in line with the requirements of Schedule 2 of the Regulations. The inspector requested the an Bord Altranais agus Cnáimhseachais na hÉireann registration numbers for all nursing staff and found that all were in place.

**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:*

Gary Kiernan  
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 report<sup>1</sup>

<b>Centre name:</b>	Shannagh Bay Nursing Home
<b>Centre ID:</b>	OSV-0000095
<b>Date of inspection:</b>	21/10/2014
<b>Date of response:</b>	17/12/2014

### 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:

Governance and management structures were not put in place to address the need for sufficient staffing resources in the centre.

#### Action Required:

Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of

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



purpose.

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

Following an extensive recruitment drive, 2 CNM posts have been filled and both staff have commenced orientation. CNM 1 commenced employment on 01/12/14. CNM 2 commenced employment on 28/11/14.

CNM 2 was on orientation and after 4 days, they left employment as they had to travel quite a distance to work and they found this to be an unsustainable commute. Since then another CNM has been interviewed and offered the position and Shannagh Bay are currently awaiting a decision.

We have recruited a nurse into the staff nurse role and they commenced employment on 10/11/12. This nurse has completed orientation and is now working on the floor under the supervision and guidance of colleagues, CNM and PIC.

Shannagh Bay Healthcare Ltd have reviewed the dependency requirements in regard to ensuring adequate direct care hours by using an accredited dependency assessment tool and found the staffing levels of both qualified and unqualified staff met with the needs of the current residents in Shannagh Bay.

Dependency Levels will be reviewed when resident condition changes and at a minimum of four months by the PIC to ensure the staffing levels can meet the direct care needs of residents.

**Proposed Timescale:** 17/12/2014

**Theme:**

Governance, Leadership and Management

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

Effective systems were not in place to monitor the safety and quality of care delivered to residents.

**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:**

1) We now have a scheduled audit of resident care plans using a detailed consistent tool allowing scoring. This enables on-going monitoring and trending of the scores. (commenced)

2) The results are communicated to the appropriate nurse who is the key worker. The nurses are also provided with a detailed action plan to be completed within a specified timeframe.

3) The PIC checks the actions have been completed, again scoring the completion of

the action plan.

4) Failure to complete the action plan is communicated to the relevant key nurse and also discussed at weekly team meetings.

5) There is a plan that should the action still not be completed, disciplinary proceedings will commence.

Plan to manage Staff Recruitment, Staff Retention and Sick Leave:

6) In all new staff contracts, staff are now required to give six weeks' notice to terminate employment, this will give adequate time to recruit new staff and to ensure they have sufficient induction time to take on the role.

7) We have multiple contracts with recruitment agencies which enables us a very broad scope to advertise all vacancies.

8) All vacancies are also posted on our website

9) In the new year we plan to forecast rosters to enable us to identify any times/areas where staff shortages occur and will give us adequate time to recruit the necessary staff

10) Also going forward we will look for staff who are looking for long term, permanent positions as opposed to staff who are looking to fill in some time before starting college

11) In an effort to retain staff PIC is spending more time with the staff on a daily basis, supporting them in their various roles.

12) Staff are encouraged and supported to discuss any concerns relating to their role or the care of the residents

13) The rosters are balanced to ensure there are always more experienced members of staff to support the new staff members

14) The four senior care assistant who have been appointed will also assist in this role and will act as a 'Buddy' to all new staff

15) New staff will not be allocated to any of the special tasks i.e. one-to-one care, until such time as they are comfortable in the role and know the residents very well

16) To manage the sick leave, all staff now have to attend a back to work interview following all sick leave – where all issues relating to sick leave will be discussed.

Quality and Safety of Care & Quality of Life:

17) Resident Questionnaires have been distributed or sent to relatives/carers to seek feedback on the quality and safety of care given in Shannagh Bay.

18) A full review of the activities provided on an individual level has been completed. Following this, a detailed plan is being put in place for all residents, specific to their wishes, requests and abilities

19) As part of the Multidisciplinary Team Plan, the physiotherapist will do a full assessment on each resident, which will be documented in the resident's health record (in epic)

20) On-going meetings with the Multidisciplinary Team that will discuss any changes with the residents, new policies, audit results and on-going QIP's

21) Supervision of staff has been implemented, especially in regard to wound management

**Proposed Timescale:** 28/02/2015

**Outcome 03: Information for residents**

**Theme:**

Governance, Leadership and Management

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

The contracts of care provided to residents did not deal with all fees which were charged to residents.

**Action Required:**

Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

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

- 1) There is now a more robust system in place to prevent incorrect invoicing errors in the future.
- 2) The PIC will carry out an audit of >50% of residents that are having internal financial management every 6 months to check the invoicing.
- 3) The contracts have been amended to reflect physiotherapy charge gives access to everyone to have any therapy required.
- 4) The contracts have been amended to identify a charge for social activities and sundries at a rate of 2 euro per day.
- 5) An amendment sheet has been generated and sent to all families/carers explaining the changes to the contract of care.

**Proposed Timescale:** 31/01/2015

**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:**

The risk management policy referred to in outcome 8 was not implemented with regard to residents who smoke.

**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:**

All residents who smoke had an assessment that was within date, they were in a hard folder housed in the nurse's station (these have now been scanned into their records). Shannagh Bay accept that on the day 1 off the inspection, this could not be located. In spite of this, all staff were knowledgeable on the smoking policy and were also knowledgeable about which residents require supervision while smoking. All the smoking assessments have now been reviewed and are all currently in the resident's files in Epic.

**Proposed Timescale:** 19/12/2014

**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:**

Five staff members did not have up to date training in protection and safeguarding.

**Action Required:**

Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

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

5 at the time of the inspection were out of date in elder abuse training which occurs every 24 months as per policy.

**Action:**

The 5 staff that did not have current (within two years) Elder Abuse Training, have completed the training since the inspection. (07/11/14 & 14/11/14)

6 members of staff now require Elder Abuse training and this will be completed on the 6th & 7th January 2015

The policy will be reviewed to reflect that all staff will now have a refresher hand-out 12 months after training, therefore all staff will have had training every 24 months and refresher every 12 months.

**Proposed Timescale:** 19/12/2014

**Theme:**

Safe care and support

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

The systems of charging fees to residents did not protect residents from the risk of financial abuse and required review.

**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:**

1) There is now a more robust system in place to prevent incorrect invoicing errors in the future.

2) The PIC will carry out an audit of >50% of residents that are having internal financial management every 6 months to check the invoicing.

- 3) An amendment sheet has been generated and sent to all families/carers explaining the changes to the contract of care.
- 4) The log book for the shop items will now be checked weekly to ensure all items have a signature as per procedure. This will be checked by the PIC or general manager.
- 5) The contract of care has been amended to demonstrate the services received for the physiotherapy charge. This now includes recording of the attendees at the weekly physiotherapy sessions, epic log of any one-to-one physio session and an assessment for all residents.

**Proposed Timescale:** 06/03/2015

### **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:**

A small number of staff had not undertaken the necessary fire training.

**Action Required:**

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

- 1) The 4 new members of staff who did not have Fire Training at the time of the inspection have now been trained.
- 2) All new staff will have fire training as part of their induction programme within the first week.
- 3) All staff will attend Fire Warden and Fire Evacuation training the week commencing January 26th and all training will be completed over a two week period

**Proposed Timescale:** 18/12/2014

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

**Theme:**

Effective care and support

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

Arrangements were not in place to ensure that residents' basic care needs in areas such as toileting and going back to bed were met in a timely way. Arrangements for meeting residents' social care needs were not satisfactory.

**Action Required:**

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

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

- 1) Staff will have feedback/training on the importance of meeting essential basic needs of residents such as toileting and any other requests. Completed 11/12/14
- 2) This will be supported by the appointment of 4 senior carers within the team with specific mentoring, overseeing duties Completed 12/11/14
- 3) The PIC will be monitoring on an on-going basis by observation, weekly staff meetings and seeking resident feedback.
- 4) Appointment of an extra CNM to also monitor performance and the standards expected.
- 5) A full review of activities has occurred Completed 4th December 2014
- 6) An action plan has been developed and implemented to address the issues related to activities.
- 7) Activity assessments, mobility assessments and activity care plans are to be fully reviewed and amended as required, by the Occupational Therapist and Overseen by the PIC.

**Proposed Timescale:** 31/01/2015

**Theme:**

Effective care and support

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

Residents who were readmitted to the centre did not have their needs reassessed following a change in their condition.

**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:**

- 1) Staff sessions and weekly meetings addressing the 48 hour policy for reassessing residents who return from hospital.
- 2) Any resident requiring reassessment following hospital stay will be checked by the PIC.
- 3) Have a scheduled audit of resident care plan using a detailed consistent tool allowing scoring. This enables on-going monitoring and trending of the scores.
- 4) The results are communicated to the appropriate nurse who is the key worker. The nurses are also provided with a detailed action plan to be completed within a specified timeframe.
- 5) The PIC checks the actions have been completed, again scoring the completion of the action plan.
- 6) Failure to complete the action plan is communicated to the relevant key nurse and also discussed at weekly team meetings.

7) There is a plan that should the action still not be completed, disciplinary proceedings will commence.

**Proposed Timescale:** 28/02/2015

**Theme:**

Effective care and support

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

Care plans were not formerly reviewed where there was a change in the condition of residents.

**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:**

- 1) The resident in question had his care-plans and assessments reviewed and undated immediately.
- 2) The PIC will ensure all visiting members of the MDT and the GP who make any changes in the care/treatment, goals, instructions and/or evaluation, will have the information recorded in the residents notes and passed on to all staff.
- 3) There is a scheduled audit of all resident care plans using a detailed consistent tool allowing scoring. This enables on-going monitoring and trending of the scores.
- 4) The results are communicated to the appropriate nurse who is the key worker. The nurses are also provided with a detailed action plan to be completed within a specified timeframe.
- 5) The PIC checks the actions have been completed, again scoring the completion of the action plan.
- 6) Failure to complete the action plan is communicated to the relevant key nurse and also discussed at weekly team meetings.
- 7) There is a plan that should the action still not be completed, disciplinary proceedings will commence.

**Proposed Timescale:** 28/02/2015

**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 care was not demonstrated in relation to wound management.

**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:**

- 1) The Wound management policy is now approved and distributed to all staff via Q pulse.
- 2) PIC will train all new staff in regard to the complex dressings of some of the residents.
- 3) Any Tissue viability Nurse reviews shall be recorded into the Epic Care system and overseen by the PIC.

**Proposed Timescale:** 17/12/2014

**Outcome 13: Complaints procedures**

**Theme:**

Person-centred care and support

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

A satisfactory record of complaint investigation and outcome was not maintained.

**Action Required:**

Under Regulation 34(1)(f) you are required to: 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.

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

The complaint reviewed at the time of the inspection was still under the process and response had been sent to the complainant and a response from the complainant is awaited. It had been requested, therefore at the time, the outcome could not be recorded.

Update 15/12/14- The complainant has been contacted again and he has responded by informing the PIC that he is currently too busy to respond, so the complaint is still open.

Action: PIC will follow the policy and close as soon as an outcome has been received.

**Proposed Timescale:** 17/12/2014

**Outcome 18: Suitable Staffing**

**Theme:**



Workforce

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

There was evidence of ineffective delivery of care for residents as a result of inadequate numbers and skills mix of staff.

**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:**

- 1) Resident dependency review has been carried out as mentioned above and will be reviewed every four months or sooner if a residents condition changes.
- 2) Full recruitment of staff completed, however one CNM left shortly after starting due to excessive commuting- therefore another interviewee has been offered the position and confirmation/decline awaited.
- 3) All Staff have received feedback at the weekly staff nurse meetings, the PIC has met with HCA's regarding the expected standards of care at all times.
- 4) Appraisal procedure to be implemented- now process mapped and agreed.
- 5) Professional development plans to be done with each member of staff. Should competencies issues be identified, this will be recorded and overseen by the PIC and the CNM.
- 6) Disciplinary action policy reviewed and approved. To be implemented as required to ensure high levels of care are provided to residents at all times.

**Proposed Timescale:** 28/02/2015