<table>
<thead>
<tr>
<th><strong>Centre name:</strong></th>
<th>Shannon Lodge Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Centre ID:</strong></td>
<td>OSV-0000383</td>
</tr>
<tr>
<td><strong>Centre address:</strong></td>
<td>Rooskey, Roscommon.</td>
</tr>
<tr>
<td><strong>Telephone number:</strong></td>
<td>071 965 8667</td>
</tr>
<tr>
<td><strong>Email address:</strong></td>
<td><a href="mailto:shannonlodgenh@gmail.com">shannonlodgenh@gmail.com</a></td>
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<tr>
<td><strong>Type of centre:</strong></td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td><strong>Registered provider:</strong></td>
<td>Shannon Lodge Nursing Home Rooskey Limited</td>
</tr>
<tr>
<td><strong>Provider Nominee:</strong></td>
<td>Adrian Cox</td>
</tr>
<tr>
<td><strong>Lead inspector:</strong></td>
<td>PJ Wynne</td>
</tr>
<tr>
<td><strong>Support inspector(s):</strong></td>
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</tr>
<tr>
<td><strong>Type of inspection:</strong></td>
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</tr>
<tr>
<td><strong>Number of residents on the date of inspection:</strong></td>
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<tr>
<td><strong>Number of vacancies on the date of inspection:</strong></td>
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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 to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 20 May 2015 09:00
To: 20 May 2015 17:30

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

<table>
<thead>
<tr>
<th>Outcome 01: Statement of Purpose</th>
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<td>Outcome 02: Governance and Management</td>
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<td>Outcome 03: Information for residents</td>
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<td>Outcome 04: Suitable Person in Charge</td>
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<td>Outcome 05: Documentation to be kept at a designated centre</td>
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<td>Outcome 06: Absence of the Person in charge</td>
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<td>Outcome 07: Safeguarding and Safety</td>
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<td>Outcome 08: Health and Safety and Risk Management</td>
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<td>Outcome 09: Medication Management</td>
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<td>Outcome 11: Health and Social Care Needs</td>
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<td>Outcome 14: End of Life Care</td>
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<td>Outcome 15: Food and Nutrition</td>
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<tr>
<td>Outcome 17: Residents’ clothing and personal property and possessions</td>
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<tr>
<td>Outcome 18: Suitable Staffing</td>
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Summary of findings from this inspection
This report set out the findings of an unannounced monitoring inspection. This inspection took place over one day. The inspector reviewed progress on the action plan from the previous inspection carried out in February 2014. Notifications of incidents received since the last inspection was also considered and reviewed on this visit.

The centre was clean, warm and well decorated with a calm atmosphere. Residents were complimentary of staff and satisfied with care services provided. They had good access to nursing, medical and allied health care. Residents had opportunities to participate in meaningful activities, appropriate to their interests and capacities.

A total of 14 Outcomes were inspected. The inspector judged three Outcomes as moderately non compliant. These included Governance and Management, End of life Care and Suitable Staffing. Seven Outcomes were judged as compliant with the Regulations and a further four as substantially in compliance with the Regulations.
The areas of moderate non compliance primarily related to;

The staffing level on duty at the time of inspection did not match the roster.

Residents with a do not resuscitate (DNR) status in place did not have the DNR status regularly reviewed to assess the validity of clinical the judgement on an ongoing basis.

No audits had been completed to date for 2015 to date. The quality assurance program requires further expansion to review additional areas which impact on resident’s wellbeing and quality of life.

The action plan at the end of this report identifies these and other areas where improvements must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.
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 01: Statement of Purpose

**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:**

The Statement of Purpose was last updated in January 2015. The Statement of Purpose set out the services and facilities provided in the designated centre and contained all the requirements of Schedule 1 of the Regulations.

**Judgment:**

Compliant

### Outcome 02: Governance and Management

**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):**

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

**Findings:**

There was a defined management structure in place to ensure the effective governance of the service. The inspector found that the management structure was appropriate to the size, ethos, purpose and function of the centre.

The inspector found that the management structure was appropriate to the size, ethos,
and purpose and function of the centre. There was an organisational structure in place to support the person in charge. The provider met with the inspector and discussed the governance and operational overview required by his role.

There was evidence of quality improvement strategies and monitoring of the services. The inspector reviewed audits completed by the clinical nurse manager. There were three audits completed during 2014. These included hygiene, nutritional and menu planning and an audit of the medication prescription and administration charts. The number of residents with bedrails in use has increased since the last inspection. However there was no audit or review planned to investigate this trend.

No audits had been completed to date for 2015 and no data was being collected to identify trends. The quality assurance program requires further expansion to review additional areas which impact on resident’s wellbeing and quality of life.

An annual report on the quality and safety of care was not compiled for 2014 with copies made available to the residents or their representative for their information as required by the Regulations.

Judgment:
Non Compliant - Moderate

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

**Findings:**
The inspector found that all residents had an agreed written contract. The contract of care was revised as this was an area identified for improvement on the last inspection.

The cost of additional expenses incurred by residents was set out in the revised contract of care. This identified charges payable per items not included in the overall fee.

Judgment:
Compliant

**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:
The person in charge is a registered nurse and is noted on the roster as working in the post full-time. She had good knowledge of residents care needs. She could describe in an informed way where residents had specific needs and how staff ensured that their care needs were met appropriately.

She has maintained her professional development and attended mandatory training required by the Regulations. The person in charge is a qualified trainer in safe moving and handling techniques and adult protection.

There is dedicated time allocated to manage the clinical governance and administration duties required by the post of person in charge. The person in charge is supported in her role by a clinical nurse manager.

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

Findings:
The inspector found that there were systems in place to maintain complete and accurate records. Records were stored securely and easily retrievable.

Written operational policies, which were centre specific, were in place to inform practice and provide guidance to staff.

A sample of four staff files were examined to assess the documentation available, in respect of persons employed. All the information required by Schedule 2 of the
Regulations was available in the staff files reviewed. This was an area identified for improvement in the action plan of the previous inspection report.

**Judgment:**
Compliant

### Outcome 06: Absence of the Person in charge

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The provider was aware of the requirement to notify the Chief Inspector of the proposed absence of the person in charge for a continuous period of 28 days. The key senior manager is appointed to deputise while the person in charge is absent. This has occurred on one occasion to date.

**Judgment:**
Compliant

### 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 policy on adult protection was available. Protected disclosure procedures to guide staff in their reporting of a suspicion of abuse were documented in the policy. Residents spoken with stated that they felt safe in the centre. There was a visitors log in place.

No notifiable adult protection incidents which are a statutory reporting requirement to the Authority have been reported since the last inspection.
Staff spoken to were able to inform the inspector of what constituted abuse and of their duty to report any suspected or alleged instances of abuse. Staff identified a senior manager as the person to whom they would report a suspected concern. The inspector viewed records confirming all staff had up to date refresher training in protection of vulnerable adults.

There is a policy on the management of behaviour that is challenging. Staff spoken to were very familiar with resident’s behaviours and could describe particular residents daily routines very well to the inspector. Staff had completed training on caring for older people with cognitive impairment or dementia. This training included components to respond to challenging behaviours. There were some residents with behaviours that challenge that did not have a diagnosis of dementia or cognitive impairment. The person in charge indicated they would review the training program to encompass broader aspects of managing behaviours that challenge in future training.

There was a policy on restraint management (the use of bedrails and lap belts) in place. This was adapted from the HSE national policy on promoting a restraint free environment. At the time of this inspection 11 residents had two bedrails in use. There was a risk assessment completed prior to the use of the restraint and assessments were regularly revised. Signed consent was obtained by the resident or their representative and the GP. Restraint risk assessments were revised routinely and supported with a plan of care. Crash mats, sensor alarms and ultra low beds were in use to promote a restraint free environment. The rationale for each bed rail was outlined in the risk assessment documentation reviewed. However, there was limited detail on alternatives trialled and why they were unsuccessful in some of the assessments examined. The assessments simply stated ‘no alternatives suitable’.

**Judgment:**
Substantially Compliant

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

**Findings:**
The inspector was satisfied that the health and safety of residents, staff and visitors in the centre was promoted and protected. The actions in the previous inspection which related to risk, health and safety were satisfactorily completed.

The governance arrangements to manage risk situations were specified. Responsibility for health and safety procedures and an organisational safety structure was included in the risk management policy. The health and safety statement and risk assessments...
were newly developed in April 2015.

Fire safety equipment including the fire alarm, fire fighting equipment, emergency lighting and smoke detectors were provided and were serviced annually. Evacuation sheets were fitted to each bed. Illuminated fire exit signage was in place. Action notices detailing the procedures to take in the event of discovering a fire or on hearing the alarm were displayed.

All staff had completed training in fire safety evacuation procedures. Records indicated three fire drill practices were completed. The fire drill records only recorded the time taken for staff to respond to the alarm in one drill undertaken. The drills did not record the scenario/type of simulated practice. Records did not evidence simulated fire drills are undertaken to reflect a night time situation when staffing levels are reduced. There was no evaluation of learning from fire drills completed to help staff understand what worked well or identify any improvements required.

There were was one resident who smoked at the time of this inspection. A risk assessment was completed. A plan of care was in place detailing the level of assistance and supervision required. Cigarettes and lighters were held in safekeeping by staff both during the day and at night.

The building, bedrooms and bathrooms were visually clean. However, the cleaning system in place required review to break the cycle of infection and minimise the risk of cross contamination. There were separate mops to clean each bedroom and ensuite bathroom. However, cleaning cloths were not changed between cleaning each ensuite bedroom.

There were arrangements in place for recording and investigating untoward incidents and accidents. The inspector noted that falls and near misses were well described. In the sample of accident report forms reviewed vital signs for residents were checked and recorded. Neurological observations were recorded where a resident sustained an unwitnessed fall or a suspected head injury. Individual strategies were outlined and utilised to minimise the risk of residents sustaining a fall. A post incident review was documented and a plan of action identified where necessary.

The training records showed that staff had up-to-date refresher training in moving and handling. There was sufficient moving and handling equipment available to staff to meet residents needs. Each resident’s moving and handling needs were identified and outlined on the nurse handover report sheet. This report detailed all residents with a high risk falls and those requiring the use of a hoist and size of sling.

Judgment:
Substantially Compliant

**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:
There was a comprehensive medication management policy in place which provided guidance to staff to manage aspects of medication from ordering, prescribing, storing and administration.

Each resident’s medication was dispensed from blister packs. The blister packs on arrival were checked against the prescription sheets in the signed kardex to ensure all medication orders received were correct for each resident. Drugs which were crushed prior to administration were prescribed and signed by the GP.

The inspector reviewed a sample of drugs charts. Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. The prescription sheets reviewed were legible and distinguished between PRN (as needed), regular and short term medication.

The medication administration sheets viewed were signed by the nurse following administration of medication to the resident and recorded the name of the drug and time of administration. The drugs were administered within the prescribed timeframes. There was space to record when a medication was refused on the administration sheet.

Medications that required strict control measures were kept in a secure cabinet which was double locked in keeping with the Misuse of Drugs (Safe Custody) Regulations. Nurses kept a register of controlled drugs. Controlled drugs were checked by two nurses at the change of each shift. The inspector checked a selection of the balances and found them to be correct.

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):
Findings:
There were 34 residents in the centre during the inspection and two beds were vacant. The majority of the residents were residing in the centre for continuing care and two were admitted for convalescent. There were 14 residents with maximum care needs. Three residents were assessed as highly dependent and nine with medium dependency care needs. Eight residents were considered low dependency. Many residents were noted to have a range of healthcare issues and the majority had more than one medical condition.

The inspector reviewed four resident’s care plans in detail and certain aspects within other plans of care. In the sample of care plans reviewed there was evidence care plans were updated at the required intervals or in a timely manner in response to a change in a resident’s health condition. On admission a comprehensive assessment of needs was completed, reviewed and updated at regular intervals. There was evidence of consultation with residents or their representative in care plans. However, care plans for newly admitted residents while developed did not contain documentary evidence of agreement with the residents or their next of kin.

The arrangements to meet residents’ assessed needs were set out in individual care plans. The inspector found a good standard of evidence-based care and appropriate medical and allied health care access. A range of risk assessments had been completed and were used to develop care plans that were person-centred, individualised and described the current care to be given. Care plans for residents described well their level of independence and what they could do for themselves.

The inspector reviewed the care files of the two residents accommodated for short term care. A comprehensive suite of risk assessments to identify all their care needs was not completed. A moving and handling risk assessment was not completed for one resident. Another did not have a care plan to outline the post surgery guidance issued by the hospital. There was evidence in the nursing notes of one resident of contact with the public health nurse to plan for a home discharge. However, each resident did not have a discharge care plan completed to guide staff in their rehabilitive goals and ensure a safe discharge.

Residents had access to general practitioner (GP) services and there was evidence of medical reviews at least three monthly and more frequently when required. Medical records evidenced residents were seen by a GP within a short time of being admitted to the centre. A review of residents’ medical notes showed that GP’s visited the centre regularly. The GP’s reviewed and re-issued each resident’s prescriptions every three months. This was evidenced on reviewing medical files and drug cards.

Access to allied health professionals to include speech and language therapist, dietetic service, and psychiatry was available. The consultant psychiatrist and their team visit the centre as required reviewing residents. Medication is reviewed to ensure optimum therapeutic values.

There were no residents with pressure or vascular wounds at the time of this inspection. The inspector reviewed the care plan for one resident with a healed wound. Advice was
obtained from a clinical nurse specialist in wound care. The resident attended a vascular clinic and was reviewed by a consultant.

There were opportunities for residents to partake in activities. An activity coordinator was employed for four days each week. On the morning of the inspection a number of residents participated in a local outing to a nearby town.

**Judgment:**
Substantially Compliant

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**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):**
No actions were required from the previous inspection.

**Findings:**
There was an end-of-life care policy detailing procedures to guide staff. The policy of the centre is all residents are for resuscitation unless documented otherwise. A multidisciplinary approach was undertaken to include the resident where possible, their representative, the GP and the nursing team. Residents with a do not resuscitate (DNR) status in place did not have the DNR status regularly reviewed to assess the validity of clinical the judgement on an ongoing basis.

Where the need was identified and the resident consented or their next of kin, referrals were made to the palliative care team. Records reviewed evidenced good input by the palliative team to monitor and ensure appropriate comfort measures. There was one resident at the time of this inspection receipt of palliative care. Medication was regularly reviewed and closely monitored to ensure optimum therapeutic values.

Each resident had a plan of care for end-of-life. The care plans contained good detail of personal or spiritual wishes. However, there were no decisions concerning future healthcare interventions. Resident’s preferences with regard to transfer to hospital if of a therapeutic benefit were not documented in end-of-life care plans.

The majority of staff had received end-of-life training during 2014.

**Judgment:**
Non Compliant - Moderate

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**Outcome 15: Food and Nutrition**

*Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.*
**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
There was ongoing monitoring of residents’ nutritional and hydration needs. Staff monitored the food and fluid intake of residents identified with a nutritional risk. Food intake records were well completed consistently and included the amount of prescribed supplements consumed. Fluid charts were totalled.

The majority of staff had undertaken training on safe feeding practices for residents and in nutritional care for the elderly. Staff demonstrated and articulated good knowledge of how to provide optimal care for resident.

**Judgment:**
Compliant

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**Outcome 17: Residents’ clothing and personal property and possessions**
Adequate space is provided for residents’ personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

**Theme:**
Person-centred care and support

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

**Findings:**
The inspector reviewed a policy for the managing of residents’ personal property. It provided guidance to staff on the storage and care of residents’ belongings. Property list were completed.

There was evidence that residents had adequate space for their belongings, including secure lockable storage. Each resident was provided with their own wardrobe.

The system in place to ensure all clothes were identifiable to each resident requires review. The inspector checked items of clothing in residents’ wardrobes and noted names were not recorded on all clothing. In one wardrobe two items of clothing were noted which did not belong to the particular resident.

**Judgment:**
Substantially Compliant
**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 staff level on duty at the time of inspection did not match the roster. The person in charge was recorded on the roster to work from 7:45 to 17:00. However, the person in charge was not in the centre at the commencement of the inspection. There was conflicting information provided to the inspector. Some staff indicated the person in charge was on leave and due to return the following day. Another staff member indicated the person in charge was undertaking a pre admission assessment of a prospective resident.

The clinical nurse manager was rostered for duty at 8:00 hrs. However, the clinical nurse manager did not commence her work shift until 10:00 hrs. The nurse on duty was aware the clinical nurse manager was starting at a later time. However, no additional staff were rostered to cover the shortfall in nursing staff.

Throughout the inspection residents appeared to be very content with the staff members on duty. Staff demonstrated a good rapport and knowledge of the residents.

There was a training matrix available which conveyed that staff had access to ongoing education and a range of training was provided. In addition to mandatory training required by the Regulations staff had attended training on infection control, cardio pulmonary resuscitation techniques, medication management and food safety.

**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:

PJ Wynne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

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<tr>
<th>Centre name:</th>
<th>Shannon Lodge Nursing Home</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000383</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>20/05/2015</td>
</tr>
<tr>
<td>Date of response:</td>
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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:
No audits had been completed to date for 2015 and no data was being collected to identify trends. The quality assurance program requires further expansion to review additional areas which impact on resident’s wellbeing and quality of life.

Action Required:
Under Regulation 23(c) you are required to: Put in place management systems to

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
ensure that the service provided is safe, appropriate, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**
Review of the quality assurance programme has taken place. Relevant Audits will be completed for 2015, and a schedule is in place. Feedback with results and trends will be communicated through resident meetings. Commencement in July and completion for 2015

**Proposed Timescale:** 31/12/2015

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
An annual report on the quality and safety of care was not compiled for 2014 with copies made available to the residents or their representative.

**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 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:**
Feedback will be made available to residents following outcomes and trends of audits at the end of the year.

**Proposed Timescale:** 31/12/2015

**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:**
There was limited detail in restraint assessments on alternatives trialled and why they were unsuccessful in some of the examples examined. The assessments simply stated ‘no alternatives suitable’.

**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:
Restraints are reviewed every three months by the multi disciplinary team. Residents currently using side rails are at immediate risk of falls. Alternatives where appropriate are used initially and the restraint document will be modified to ensure a more detailed summary and outcomes of the alternatives used.

**Proposed Timescale:** 31/07/2015

### 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:**
The cleaning system in place required review to break the cycle of infection and minimise the risk of cross contamination. Cleaning cloths were not changed between cleaning each ensuite bedroom.

**Action Required:**
Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

**Please state the actions you have taken or are planning to take:**
New colour coded cleaning cloths have been purchased and are currently in use. Cleaning cloths are now changed between each ensuite room.

**Proposed Timescale:** 07/07/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Fire drills did not record the scenario/type of simulated practice. Records did not evidence simulated fire drills are undertaken to reflect a night time situation when staffing levels are reduced. There was no evaluation of learning from fire drills completed to help staff understand what worked well or identify any improvements required.

**Action Required:**
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.
Please state the actions you have taken or are planning to take:
Documentation will be reviewed and more detailed scenarios and role plays will be simulated in practice to ensure all staff are competent in fire safety. Evaluation and feedback will be compiled and added to demonstrate learning, and identify improvements in drills.

Proposed Timescale: 07/07/2015

**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:**
Care plans for newly admitted residents while developed did not contain documentary evidence of agreement with the residents or their next of kin.

**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:**
Newly admitted residents are assigned to staff nurse, care plans to be completed within one week and signed with resident and/or NOK.

Proposed Timescale: 31/07/2015

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Care files of the two residents accommodated for short term care. A comprehensive suite of risk assessments to identify all their care needs was not completed. Each resident did not have a discharge care plan completed to guide staff in their rehabilitive goals and ensure a safe discharge.

**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 revised respite folder has been compiled to include a more detailed assessment/discharge plan. This ensures a more comprehensive admission going forward for short term residents.

**Proposed Timescale:** 07/07/2015

### 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:**
Residents with a do not resuscitate (DNR) status in place did not have the DNR status regularly reviewed to assess the validity of clinical the judgement on an ongoing basis.

**Action Required:**
Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

**Please state the actions you have taken or are planning to take:**
On three monthly reviews with GP, DNR status will be reviewed and documented to ensure the validity of clinical judgement on an ongoing basis.

**Proposed Timescale:** 30/09/2015

**Theme:**
Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There were no decisions concerning future healthcare interventions in end of life care plans. Resident’s preferences with regard to transfer to hospital if of a therapeutic benefit were not documented.

**Action Required:**
Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

**Please state the actions you have taken or are planning to take:**
This will be discussed within the end of life care plan with the resident/NOK. End of life care plans will be more detailed from a holistic approach.

**Proposed Timescale:** 07/07/2015
### Outcome 17: Residents’ clothing and personal property and possessions

**Theme:**
Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The system in place to ensure all clothes were identifiable to each resident requires review.

**Action Required:**
Under Regulation 12(a) you are required to: Ensure that each resident uses and retains control over his or her clothes.

**Please state the actions you have taken or are planning to take:**
An Audit has been carried out in relation to clothes. Care assistants has been assigned three residents to ensure that wardrobes are tagged and kept tidy

**Proposed Timescale:** 07/07/2015

### Outcome 18: Suitable Staffing

**Theme:**
Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The staff level on duty at the time of inspection did not match the roster. No additional staff were rostered to cover the shortfall in nursing 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:**
The Roster has been reviewed and a more clearly communicated format will be available.

**Proposed Timescale:** 07/07/2015