Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Shannon Lodge Nursing Home
Name of provider:	Shannon Lodge Nursing Home Rooskey Limited
Address of centre:	Main Street, Rooskey, Roscommon
Type of inspection:	Unannounced
Date of inspection:	12 October 2021
Centre ID:	OSV-0000383
Fieldwork ID:	MON-0033797

About the designated centre

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

Shannon Lodge Nursing Home is a purpose-built bungalow-style facility located in the village of Rooskey, Co. Roscommon. It is a short drive from the N4 Dublin-Sligo road and a fifteen-minute drive from the town of Mohill. The centre provides care for 36 residents with a range of care needs from low to maximum. The nursing home is organised over two levels. All resident accommodation is on the ground floor, and the upper floor is allocated to office space and staff facilities. Residents' bedroom accommodation is comprised of 18 single and nine double rooms. The provider employs a staff team consisting of registered nurses, care assistants, housekeeping, catering and activity staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	27

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 12 October 2021	17:00hrs to 20:00hrs	Helena Budzicz	Lead
Wednesday 13 October 2021	09:30hrs to 14:00hrs	Helena Budzicz	Lead

What residents told us and what inspectors observed

The inspector met and spoke with 11 residents during the inspection. The overall feedback from residents was that they were well looked after. A person-centred approach was evident throughout the inspection, with residents expressing high satisfaction with their day-to-day life in the centre. The residents described to the inspector their delight that the centre managed to be COVID-19 free throughout the pandemic.

The inspector arrived unannounced at the centre, and the staff guided the inspector through the infection prevention and control measures necessary on entering the designated centre. The inspection was carried out over two days. Following an introduction, the inspector completed a tour of the premises, where they also met and spoke with residents in the day rooms and their bedroom areas. The inspector observed that some residents were relaxing by their bedsides, listening to the radio or viewing television. Other residents were sitting in the communal areas, watching television or chatting. The atmosphere in the centre was relaxed and cheerful. The inspector spent periods of time sitting in the communal area, talking with residents and observing the interactions between the residents and the staff. Most residents were viewing the news, which was being shown on the large flat-screen television. The inspector observed that a variety of drinks and snacks were offered. Residents commented positively about the quality and variety of food in the centre.

Shannon Lodge nursing home is a two-storey building registered to provide care for 36 residents in the town of Rooskey, County Roscommon. On the day of this inspection, there were 27 residents living in the centre. Bedroom accommodation consists of 18 single and nine double rooms, all with en-suite facilities. Overall, the premises were bright and clean throughout. The inspector observed that the centre was well-maintained. One of the communal areas had a piano and antique-style furniture. There were built-in shelves around the corridors with old-style items such as phones, cameras, and binoculars. The inspector observed that some residents bedrooms were personalised with memorabilia, pictures, soft furnishings and ornaments. The dining room was beautifully painted with a feature wall mural. The corridors were well lit and decorated with colourful photographs and artwork. There were grab rails in place along all the corridors to assist residents with mobility. There was a staff room available on the first floor with sufficient space to ensure social distancing was maintained. The inspector observed that the call bells were answered promptly.

There were two activities coordinators employed by the centre. A monthly newsletter was produced giving residents the news and activities in the centre with pictures and photographs; for example, Halloween barmbrack recipe, staff, religious/important dates of interest and autumn crosswords in the October edition. The activities board and calendar was displayed on the corridor and in the communal areas in the centre. The inspector observed that staff interacted with residents in a friendly and respectful manner and also demonstrated empathy and

gentle encouragement in their interactions with residents.

The inspector saw visiting taking place throughout the day and observed that COVID-19 infection control procedures were complied with by visitors. The inspector had an opportunity to speak with three visitors. Visitors stated that they were kept up-to-date with all affairs and updates regarding COVID-19 precautions and that they were grateful to the management and staff for working tirelessly during the pandemic and for keeping their loved ones safe. A large number of letters and complimentary cards were seen from relatives, which commended staff for their professionalism and kindness.

The next two sections will present an overview of the governance and management capability of the centre and the quality and safety of the service provider and present the findings under each of the individual regulations assessed.

Capacity and capability

The centre was well managed by an established management team who were focused on improving residents' wellbeing. The management structure was clear, and the lines of authority and accountability were clearly outlined and reflected the statement of purpose. The centre was adequately resourced and had a history of good compliance with the regulations.

Shannon Lodge nursing home is operated by the Shannon Lodge Nursing Home Rooskey Limited, which is the registered provider. The centre was managed on a daily basis by an appropriately qualified person in charge (PIC) responsible for the overall provision of care. The PIC was supported in their role by a clinical nurse manager and a full complement of staff, including nursing and care staff, activities coordinator, housekeeping staff, catering staff, maintenance and administrative staff. There were deputising arrangements in place for when the person in charge was absent. There was an on-call out-of-hours system in place. There were good communication systems in place for staff, including thorough handover and regular updates with regard to operational issues. Regular meetings between staff and the person in charge were also in place.

The staffing levels and skill-mix of staff on the days of inspection were appropriate to meet the needs of the residents, and there was no agency staff used at the time of inspection.

Records showed that staff had access to mandatory and professional development training, such as medication management, end-of-life care, assisting with eating and drinking, nutrition, and dementia care.

An induction programme was in place, which all new staff were required to complete. Staff had access to education and training appropriate to their role. The inspector observed that staff were supervised appropriately in accordance with their

role and responsibility. Records and documentation as required by Schedule 2 and 4 of the regulations were generally well-maintained.

The centre was well managed by an established management team who were focused on improving residents' wellbeing. The management structure was clear, and the lines of authority and accountability were clearly outlined and reflected the statement of purpose. The centre was adequately resourced and had a history of good compliance with the regulations.

Shannon Lodge nursing home is operated by the Shannon Lodge Nursing Home Rooskey Limited, which is the registered provider. The centre was managed on a daily basis by an appropriately qualified person in charge (PIC) responsible for the overall provision of care. The PIC was supported in their role by a clinical nurse manager and a full complement of staff, including nursing and care staff, activities coordinator, housekeeping staff, catering staff, maintenance and administrative staff. There were deputising arrangements in place for when the person in charge was absent. There was an on-call out-of-hours system in place. There were good communication systems in place for staff, including thorough handover and regular updates with regard to operational issues. Regular meetings between staff and the person in charge were also in place.

The staffing levels and skill-mix of staff on the days of inspection were appropriate to meet the needs of the residents, and there was no agency staff used at the time of inspection.

Records showed that staff had access to mandatory and professional development training, such as medication management, end-of-life care, assisting with eating and drinking, nutrition, and dementia care.

An induction programme was in place, which all new staff were required to complete. Staff had access to education and training appropriate to their role. From a review of the centre's training matrix, a small number of staff had either not completed or were not up-to-date with mandatory training. The inspector observed that staff were supervised appropriately in accordance with their role and responsibility. Records and documentation as required by Schedule 2 and 4 of the regulations were generally well-maintained.

The management team carried out a suite of audits for monitoring the service, including environmental, care planning, medication management, fire safety, QUIS score (The Quality of Interactions Schedule), antibiotics use etc. However, not all audits provided an action plan in relation to implementing the improvements required or the person responsible for action plan implementation and follow up review. Some of the audits were in the format of a checklist.

The inspector found that the annual regulatory review of the quality and safety of care had been undertaken last year; however, there was no evidence that this review was completed as a result of consultation with residents and their families.

All policies and procedures as outlined in Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013

had been reviewed and updated within the previous three years, although some improvements were required as detailed under Regulation 4: Written policies and procedures.

There was an accessible and effective complaints procedure. The inspector was satisfied that complaints, when received, were managed in line with the centre's complaints policy. The residents spoken with told the inspector that 'if they have had any worries they would say it to the management or staff, and they will sort it out for them'.

Regulation 15: Staffing

There were sufficient staff with appropriate skills to meet the individual and collective needs of residents. There was a registered nurse on duty at all times.

Judgment: Compliant

Regulation 16: Training and staff development

The training matrix identified that some staff were overdue attendance at safeguarding vulnerable adults from abuse. The person in charge demonstrated that the training was booked.

Judgment: Compliant

Regulation 21: Records

A review of a sample of personnel records indicated that all of the information required by Schedule 2 and 4 of the regulations was available in each staff members file. Systems were in place to ensure all new staff who joined the service were appropriately inducted and that all staff working in the centre had completed satisfactory An Garda Siochana (police) vetting.

Judgment: Compliant

Regulation 23: Governance and management

Issues identified through the audit process were not always followed up with an

action plan and quality improvement plan. For example, an audit identified trends in antibiotics use, weight loss or mattress use; however, no associated action plan was developed in response to the trends identified.

Residents were facilitated and encouraged to feedback on the service they received during the resident's meetings held in the centre. However, the annual review completed for 2020 did not include the feedback from the residents and their families.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Complaints policy had been revised and included the name of the person responsible for managing complaints in the centre and the person responsible for the oversight of complaints and how complaints were managed. Complaints were logged, investigated and the outcome of the investigation was communicated to complainants.

Judgment: Compliant

Regulation 4: Written policies and procedures

Some of Schedule 5 policies required further review to ensure that they were updated with the latest evidence-based practices. For example, the use of restrictive practice policy required an update to reflect chemical and environmental restrictive practices.

Judgment: Substantially compliant

Quality and safety

The inspector found the care and support provided to the residents of this centre to be of a good standard. There was a person-centred approach to care and the residents' well-being. Staff supported residents to maintain their independence where possible, and residents' health care needs were well met. Some improvements in respect of care planning arrangements, infection prevention and control and fire precautions were identified as further described under their respective regulations.

The general practitioner (GP) attended the centre weekly or more often if residents required review. Residents also had timely access to allied health services and specialist input from the psychiatry of old age, a geriatrician and the palliative care team as and when required.

The centre had an electronic resident care record system. Pre-admission assessments were undertaken by the person in charge to ensure that the centre could provide appropriate care and services to the person being admitted. A range of validated nursing tools was in use to identify resident health care needs. However, there were some inconsistencies in the care planning documentation as outlined under Regulation 5: Individualised assessment and care plan. The service received detailed information upon a resident's admission to the centre or upon a resident's transfer out of the centre to a receiving care facility.

Protocols were in place for symptom monitoring and health checks for residents and staff. There was a schedule in place for a booster-vaccination rollout in the centre for the residents. The provider had a COVID-19 folder that contained all up-to-date guidance documents on the management of a COVID-19 outbreak. There were sufficient supplies of Personal Protective Equipment (PPE), which were appropriately stored within the centre. Staff were observed wearing PPE such as surgical face masks appropriately. While there was evidence of good infection prevention and control practice in the centre, there were gaps in practice with regard to equipment cleaning procedures and storage, which is further detailed under Regulation 27: Infection Control.

A comprehensive risk register had been developed, which included both clinical and non-clinical risks. The safety and welfare of the residents living in the centre were promoted and kept under review by the management team.

There were measures in place to protect residents against the risk of fire. This included regular checks of means of escape to ensure they were not obstructed and checks to ensure that equipment was accessible and functioning. However, some improvements in the regular servicing of fire safety equipment and fire drills were required to enhance further the safety of the residents living in the centre.

Regulation 11: Visits

Visits were scheduled in advance, but the arrangements were flexible, and short-notice visits were seen to be organised on the day. Visits could take place in the designated visiting areas or residents' rooms. There was access to telephones and tablets to promote ongoing contact between residents and their families and friends. Residents were also supported to go outside with their loved ones.

Judgment: Compliant

Regulation 26: Risk management

There was a comprehensive risk management policy in place which met the regulatory requirements. The risk register had been updated and included those risks associated with the COVID-19 pandemic. Maintenance records showed that all equipment was serviced on a regular basis.

Judgment: Compliant

Regulation 27: Infection control

A number of issues were identified which had the potential to impact the effectiveness of infection prevention and control within the centre. This was evidenced by:

- Communal items of toiletries (wipes, continence wear) and resident's equipment were inappropriately stored in the dirty utility room. This was addressed by day two of the inspection.
- The oversight and management of residents' equipment hygiene needed to be improved. For example, an alcohol-based hand rub was inappropriately used for cleaning wheelchairs after their use.
- Implementation of clear decontamination processes was required to assist staff in identifying clean from dirty items.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Improvements were required to some aspects of fire safety management:

- Servicing of the fire alarm system and the emergency lighting system was completed on an annual basis by an external contractor who also provided an on-call service. Improvements were needed to ensure that the systems were also serviced on a quarterly basis as required by the regulation.
- Records with regard to fire drills required improvement to show the exact details of the simulated scenario and the length of time they were completed. Further assurances were requested from the provider on the second day of inspection in respect of e the safe evacuation of residents from the larger fire compartments in the centre. The person in charge submitted a record of the fire drill post the inspection which provided satisfactory assurances and committed to carrying out further drills tin the future.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The inspector reviewed a sample of residents' files and nursing documentation and found that in some cases, the care plans were not completed within 48 hours of the resident's admission, as required by the regulation.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to a general practitioner (GP) of their choice. GPs visited residents in person and were contacted and made aware if there were any changes in the resident's health or well being. Allied health professionals such as dietitian, physiotherapist, occupational therapist, speech and language therapy, and tissue viability nurse were made available to residents, either remotely or on-site, where appropriate.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' right to choice, privacy and dignity were respected in the centre. A variety of individual and group activities were provided for residents within the designated centre. Residents had access to televisions, telephones and newspapers and were able to avail of advocacy services.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

The transfer letter was available as part of the suite of templates on the computer care documentation. Following discharge back to the centre, comprehensive information was available when the resident returned to the centre.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant

Compliance Plan for Shannon Lodge Nursing Home OSV-0000383

Inspection ID: MON-0033797

Date of inspection: 13/10/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Issues identified through the audit process will be followed up with an action plan and quality improvement plan in the monthly news letters/ staff meetings to ensure learning and best practice is implemented. Residents and families will continue to be encouraged to give feedback on the service provided by Shannon Lodge during the resident's meetings held monthly and/or via surveys. Going forward this will be included in the annual review ending in 2021	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: Schedule 5 policies will be reviewed yearly in Shannon Lodge to ensure that they are in line with the latest evidence-based practices. restrictive practice policy will be updated to reflect chemical and environmental restrictive practices.	
Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The hygiene management of resident's equipment was reviewed and the implementation of a clear decontaminated process will be put in place identifying green for clean and red for dirty zones.
A new decontamination/disinfectant has been sourced and will be introduced for the management of resident's equipment.
All toiletries are now stored in a clean area including wipes and continence wear

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Servicing of the fire alarm system and the emergency lighting system is completed on an annual basis by an external contractor who also provides an on-call service. Going forward this will be serviced on a quarterly basis as required by the regulation.
Records have been updated with regard to fire drills showing the exact details of the simulated scenario and the length of time they are completed. These drills will take place throughout the year to ensure all staff have comprehensive fire training.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Shannon Lodge implements a baseline care plan for new admissions which includes the minimum healthcare information within 48 hrs of admission alongside preadmission.details. All risk assessments are completed promptly following admission.
A comprehensive careplan is developed within 7 days after admission, ensuring the residents physical, psychological, social and spiritual needs are met and the resident is included and encouraged to participate in the care planning process.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	01/12/2022
Regulation 23(e)	The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.	Substantially Compliant	Yellow	01/12/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections	Substantially Compliant	Yellow	25/10/2021

	published by the Authority are implemented by staff.			
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	15/10/2021
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	15/10/2021
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	30/06/2022
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment	Substantially Compliant	Yellow	30/01/2021

	referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.			