**Centre name:**
Shannagh Bay Nursing Home

**Centre ID:**
0095

**Centre address:**
2-3 Fitzwilliam Terrace
Strand Road, Bray
County Wicklow

**Telephone number:**
(01) 2862329

**Email address:**
info@shannaghbay.ie

**Type of centre:**
- [x] Private
- [ ] Voluntary
- [ ] Public

**Registered provider:**
Shannagh Bay Nursing Home Partnership

**Person authorised to act on behalf of the provider:**
Pauline Smith

**Person in charge:**
Anne Blount

**Date of inspection:**
5 February 2013

**Time inspection took place:**
- **Start:** 08:10 hrs
- **Completion:** 16:40 hrs

**Lead inspector:**
Linda Moore

**Type of inspection:**
- [ ] Announced
- [x] Unannounced

**Number of residents on the date of inspection:**
40 + 2 in hospital

**Number of vacancies on the date of inspection:**
2
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 their 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
- 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.
Summary of compliance with 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.

This inspection report sets out the findings of a monitoring inspection to:

- follow up matters arising from a previous inspection to ensure that actions required of the provider have been taken
- address a specific issue based on information received.

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

| Outcome 1: Statement of Purpose | □ |
| Outcome 2: Contract for the Provision of Services | □ |
| Outcome 3: Suitable Person in Charge | □ |
| Outcome 4: Records and documentation to be kept at a designated centres | × |
| Outcome 5: Absence of the person in charge | □ |
| Outcome 6: Safeguarding and Safety | □ |
| Outcome 7: Health and Safety and Risk Management | □ |
| Outcome 8: Medication Management | □ |
| Outcome 9: Notification of Incidents | □ |
| Outcome 10: Reviewing and improving the quality and safety of care | □ |
| Outcome 11: Health and Social Care Needs | × |
| Outcome 12: Safe and Suitable Premises | □ |
| Outcome 13: Complaints procedures | □ |
| Outcome 14: End of Life Care | □ |
| Outcome 15: Food and Nutrition | □ |
| Outcome 16: Residents’ Rights, Dignity and Consultation | □ |
| Outcome 17: Residents’ clothing and personal property and possessions | □ |
| Outcome 18: Suitable Staffing | × |

This follow-up inspection was unannounced and took place over one day. As part of the inspection, the inspector met with residents, relatives, and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and residents’ finances.

The purpose of this inspection was to review progress made on the actions identified in the action plan which was issued to the provider following the monitoring inspection on 17 and 18 July 2012. The report for that inspection can be accessed at www.hiqa.ie.

The inspector found that while resident's healthcare needs were being met, improvements were required in staff levels to meet the assessed needs of residents. There had been improvements to address the issues identified at the previous inspection. Improvements were still required in aspects of care such as medication.
management practices, risk management practices and privacy and dignity issues. The premises continues to require improvement.

The inspector found that five actions from the previous inspection had been fully addressed and nine actions were partly addressed. The time frame to complete the actions, apart from the premises issues, had expired.

**Actions reviewed on inspection:**

**Theme: Governance, Leadership and Management**

*Outcome 4: Records and documentation to be kept at a designated centre*

**Action required from previous inspection:**

Maintain an up-to-date record of residents called the “directory of residents” and include the information specified in Schedule 3 of the Regulations.

Put insurance cover in place against loss or damage to the property of residents including liability as specified in Regulation 26 (2).

Put in place all of the written and operational policies listed in Schedule 5 of the Regulations.

This action was partly addressed.

The inspector reviewed the directory and found that it was up to date and included the information as specified in Schedule 3 of the Regulations.

The provider had an insurance policy on display which provided insurance cover for the centre. It did not state that the liability to any resident shall not exceed €1000 for any one item. The provider said this was addressed following the previous inspection but the updated certificate could not be located.

All of the policies required in Schedule 5 of the Regulations were in place. The person in charge had reviewed a number of operational policies and procedures since the previous inspection including patient moving policy, do not attempt resuscitation policy, restraint and falls” policies. However, the inspector found that the falls and restraint policies were still not guiding practice. The person in charge said that she was continuing to review all polices to ensure they guided practice.
Theme: Safe care and support

Outcome 6: Safeguarding and safety

Action required from previous inspection:

Put in place a policy on and procedures for the prevention, detection and response to abuse.

This action was partly addressed.

The inspector viewed the policy on elder abuse and protection of vulnerable adults and found that it had been revised since the previous inspection. The policy outlined different types of abuse and provided guidance on recognising, and reporting abuse. While the policy included some of arrangements for the management of abuse, it was not specific enough to guide the practice in the centre. It still did not comprehensively include the procedure to be followed when investigating an allegation of abuse.

Since the previous inspection, seventeen staff had attended training on the protection of vulnerable adults and the inspector found that staff were clear on what constituted abuse and were aware of their responsibilities to report any suspicions of abuse.

Outcome 6: Safeguarding and safety

Action required from previous inspection:

Put in place written operational policies and procedures relating to residents’ personal property and possessions.

Ensure that a record is kept of each residents personal property signed by the resident and this record must be kept up to date.

This action was addressed.

A new system for managing residents’ finances had been implemented since the previous inspection and was found to be more robust. This process was viewed by the inspector. The policy on residents’ finances and personal property had been revised and now guided practice.
Outcome 7: Health and safety and risk management

Action required from previous inspection:

Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

Make adequate arrangements for the maintenance of all fire equipment.

This action was partly addressed and was ongoing.

The inspector found that practice generally in relation to the health and safety of residents and the management of risk promoted the safety of residents, staff and visitors. The system to identify and manage risk had been further developed since the previous inspection. However, there were still risks identified in relation to smoking, hand wash facilities and access to call bells.

The inspector noted that since the previous inspection, the health and safety committee continued to meet. The minutes of the meetings showed that clinical and environmental risks were discussed. Clinical risk was also discussed at the weekly nurses’ meetings. All residents who had fallen were reviewed and plans were discussed to minimise the risk of recurrences. The person in charge continued to review the location and time of falls and was planning to use this information to improve the service. However, while there is a physiotherapist and occupational therapist in the centre, they did not routinely review the residents who had fallen.

At the previous inspection, inspectors observed the temperature in the conservatory on the second day of the inspection exceeded the recommended temperatures for communal areas. There was now a system to review the temperature four times per day in this room and appropriate control measures had been implemented.

There was a risk management policy which had been revised since the previous inspection and met the requirements of the Regulations but it had not been fully implemented.

A risk register was in the process of being developed, and had been discussed at the health and safety committee.

However, the inspector noted that there were a number of non-clinical risks in the centre that had been identified at the previous inspection and had not been addressed. The inspector also identified additional potential risks where by the control measures in place were not adequate to promote the safety of residents.

There was no call bell in the conservatory for residents to summon assistance as required and as the supervision in this room was not robust, this may have negative outcomes for residents. See Outcome 18.
While improvements had been made to the smoking room, in that a new 30 minute fire door with a glass panel was fitted, there was no policy for the management of risks for residents who smoked. Staff were not fully aware of the risks associated with residents smoking and supervision of the residents was not adequate. Residents did not have smoking risk assessments completed and while they did have care plans for smoking, these did not guide the care delivered.

Outstanding risks identified from the previous inspection, which the provider said would be addressed when the new extension to the building was completed, included the following:

- staff members, including catering staff, continued to use the visitors' toilet on the ground floor to change their uniforms. This was an infection control risk.
- there was still limited access to hand washing facilities for staff. There was one sink available for staff in the nurse’s station on the ground floor and staff said that at times the room was inaccessible to them to wash their hands.
- the design of the cleaners’ store room continued to be an infection control risk. The inspector observed that cleaning trolleys were stored in a room off the laundry room. Staff said they brought the cleaning equipment through the laundry which was an infection control risk.

The inspector read the records of the fire equipment and noted that the emergency lighting had been upgraded throughout the centre since the previous inspection. The documentation with regards to the replacement and maintenance of this equipment was not available for review by the inspector. There was still no comprehensive record that this lighting was routinely checked or serviced.

**Outcome 8: Medication management**

<table>
<thead>
<tr>
<th>Action required from previous inspection:</th>
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<tbody>
<tr>
<td>Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.</td>
</tr>
</tbody>
</table>

This action was partly addressed.

While some of the processes in place for the management of medication were safe, secure and in accordance with current guidelines and legislation, some areas of medication management continued to require improvement.

The inspector noted that the policy in relation to self medication was now being used to guide practice. The inspector found that the resident now signed that she/he administered their own medications.

The process to prescribe and administer warfarin had improved since the previous inspection. However, nurses still did not administer insulin in line with professional guidelines. The inspector noted that staff still did not consistently record the dosage of insulin they administered to residents on the medication administration sheet.
Nurses often left the administration record blank when insulin was “not required” by the resident. This could result in a negative outcome for a resident.

Some other practices could increase the risk of medication error. The inspector noted the nurses continued to administer medications in an altered state and these had not been prescribed for this by the GP. Staff stated that they crushed medications for one resident. However, these medications had not been prescribed for crushing by the GP.

**Outcome 9: Notification of incidents**

<table>
<thead>
<tr>
<th>Action required from previous inspection:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any serious injury to a resident.</td>
</tr>
</tbody>
</table>

This action was completed.

The person in charge and provider were knowledgeable with regards to the legal requirement to notify the Chief Inspector of those incidents and accidents prescribed in the Regulations. A review of incidents showed that all serious injury had been notified to the Authority.

**Theme: Effective care and support**

**Outcome 11: Health and social care needs**

<table>
<thead>
<tr>
<th>Action required from previous inspection:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Set out each resident’s needs in an individual care plan developed and agreed with the resident.</td>
</tr>
</tbody>
</table>

Provide a high standard of evidence based nursing practice.

This action was not fully addressed.

While staff nurses had been allocated additional hours per month to write care plans, there were still some improvements required in the development of care plans and the inspector had concerns that the standard of the documentation could lead to an inconsistent service for residents. The care plans had not been developed and agreed with the residents.

The use of restraints, falls prevention and management and the care of residents with behaviours that challenge still required improvement.
Residents in the centre ranged in age from 28 to 101 years old. Services were provided to male and female residents providing long-term care, which includes residents with dementia, acquired brain injury, intellectual disability, mental health and social care needs. There were no residents receiving respite services. The dependencies of the residents were as follows.

<table>
<thead>
<tr>
<th>Dependency level of current residents as provided by the centre</th>
<th>Max</th>
<th>High</th>
<th>Medium</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Residents</td>
<td>19</td>
<td>12</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

**Restraint**

Management of restraint and the use of bedrails continued to require improvement. The restraint policy had been revised since the previous inspection but was not fully implemented. Consent forms still gave general consent for the use of a range of restraints and were not based on the individual needs of each resident.

While assessments for bedrails were in place, information about alternatives to restraint that had been considered was not sufficient. It did not indicate how long the alternative had been considered or the reason why it had not worked.

While the risks associated with the use of the bedrail had been considered and documented, there had been no risk assessment for the use of lap belts.

The restraint care plans were not sufficiently comprehensive to guide the care and staff were not knowledgeable about them. Staff described different approaches to the management of restraint to the inspector.

The inspector saw one resident who was left unsupervised in the conservatory while in restraint. The inspector discussed the seating position of one resident with the occupational therapist who found it was inappropriate and changes were made to the position.

In addition, staff were still not recording the duration of the use of restraint and there was no consistent process to observe residents while using restraint.

**Falls Management**

The inspector reviewed the policy on falls and found that it had been reviewed since the previous inspection. It now included the need for a post fall assessment and included preventative strategies. However, it had not been fully implemented.

All residents at risk of falls had a falls risk assessment completed. However, while a new post falls assessment was introduced since the previous inspection, this was not routinely completed when residents fell and the information in the assessment was not being used to update the care plan. Hence, care plans were still not updated to
reflect the changing needs of the resident including supervision arrangements. One resident who had fallen recently did not have a falls care plan in place.

Nursing staff still did not have access to the required resources to monitor residents with suspected head injuries - a comprehensive neurological chart and a pen torch. This could have very serious consequences for residents. While the person in charge said that staff completed these observations as required, there was no evidence of this in the residents’ files.

**Behaviours that Challenge**

There was a comprehensive policy on the management of behaviours that challenge, but this was still not being consistently implemented. Residents’ records had been improved since the previous inspection but were not consistent for all residents who displayed behaviours that challenge. Other issues included:

- assessments had been carried out for some but not for all residents.
- triggers that prompted behaviours and the behaviour itself were not consistently recorded
- discussions with staff members indicated that incidents of behaviour that challenged were now being logged in the incident report and the progress noted, and while an ABC chart was introduced since the previous inspection, staff were not using this, which contravened the centres’ policy
- one resident's care plan was specific and guided the care but another resident who had been aggressive toward staff did not have a care plan in place. Therefore there was no guidance to staff on the specific care needs of this resident.

Some staff were attending training in responding to behaviours that challenge on the day of the inspection and further training was planned.

**Outcome 12: Safe and suitable premises**

<table>
<thead>
<tr>
<th>Action required from previous inspection:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide sufficient numbers of toilets, and wash-basins, baths and showers fitted with a hot and cold water supply, which incorporates thermostatic control valves or other suitable anti-scalding protection, at appropriate places in the premises.</td>
</tr>
<tr>
<td>Provide a sufficient number of toilets which are designed to provide access for residents in wheelchairs, having regard to the number of residents using wheelchairs in the designated centre.</td>
</tr>
<tr>
<td>Ensure the premises are of sound construction and kept in a good state of repair externally and internally.</td>
</tr>
<tr>
<td>Keep all parts of the designated centre clean and suitably decorated.</td>
</tr>
<tr>
<td>Provide and maintain external grounds which are suitable for, and safe for use by residents.</td>
</tr>
<tr>
<td>Provide for the storage of food in hygienic conditions.</td>
</tr>
</tbody>
</table>
Provide suitable ventilation in all parts of the designated centre.

Provide suitable changing and storage facilities for staff.

This action was partly addressed.

The physical environment in Shannagh Bay Nursing Home still did not meet the requirements of the Regulations or meet the needs of specific residents. The provider said that many of the areas identified at the previous inspection would be addressed in the upcoming new extension and renovation project. Since the previous inspection, the front of the building has been repainted and the new logo was displayed. The provider said that repair work was completed on the roof.

The provider had addressed some of the maintenance issues identified at the previous inspection and said that other areas would be addressed in the renovation project. The hole in the floor in the smoking room had been repaired and the underground storage room where the fruit and vegetables were stored had been re-floored and painted.

Since the inspection, cleaning staff had received up-to-date training on infection control processes and discussed this with the inspector.

There had been two new assisted bathroom suites with assisted showers/toilets installed since the previous inspection. There was still a shortage of assisted toilets and showers for residents’ use. While there were domestic type showers in most of the en-suite bathrooms, these could only be used by mobile residents.

The inspector again found that the premises were in a poor state of repair. Some examples included worn and torn carpet outside the dining room and many of the doors throughout the premises were damaged. Some of the chairs had a strong foul odour coming from them. The provider and person in charge said they were aware of this, discussed the reasons with the inspector and their plans for addressing it.

The inspector observed there was poor ventilation in the centre and the air smelled stale throughout.

There was still inadequate storage space in the centre and the inspector observed equipment was being stored in bathrooms and on the corridors, which may impede access for residents.

There was no access to a secure outside space for residents and staff said this continued to have a negative effect on residents with behaviours that challenged.

There were two three-bedded rooms. The provider informed the inspector that he was aware of arrangements in the Authority's Standards to be put in place in relation to bedroom occupancy by 2015 and had plans in place to address it.
**Theme: Person-centred care and support**

**Outcome 16: Residents’ rights, dignity and consultation**

**Action required from previous inspection:**

A. Put in place arrangements to facilitate residents’ consultation and participation in the organisation of the designated centre.

B. Provide residents with privacy to the extent that each resident is able to undertake personal activities in private.

A. This action had been partly addressed.

There were now robust arrangements in place to facilitate residents’ consultation and participation in the organisation of the centre.

A review of the minutes of the last two resident committee meetings showed that there had been changes to the menu on foot of recommendations from this group. There was now a system to ascertain the views of residents with a cognitive impairment and some residents discussed the meeting with the inspector.

B. This action had been partly addressed.

The provider had replaced the screening on the second floor for residents in shared rooms and told the inspector that he was in the process of replacing mobile screening in all shared rooms. Mobile screening was still inappropriate and did not provide adequate screening for many residents in shared rooms when personal care was being delivered.

The inspector noted and staff confirmed that due to the lack of assisted toilets and showers available in the centre, residents continue to access other residents’ bedrooms to have a shower or use their assisted toilet which impacted on the privacy of other residents. The provider said this would be addressed in the new extension.

**Theme: Workforce**

**Outcome 18: Suitable staffing**

**Action required from previous inspection:**

Ensure that the numbers and skill-mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

This action was addressed, in that there was sufficient staff on duty to meet residents’ needs, however, as outlined previously, the inspector found that the supervision of residents in the conservatory was not adequate.
Staff told the inspector that they were not satisfied with the supervision arrangements for residents at tea time. This was not observed by the inspector on this inspection. However, the person in charge had not completed an assessment based on the needs of residents to ascertain if staff supervision at that time was sufficient.

At the previous inspection, staff told inspectors that due to their terms and conditions, they were very unhappy in their work. Inspectors had found that residents were aware of staff dissatisfaction and this caused them undue worry. At that time, the person in charge was aware of these issues and was actively trying to address them.

At this inspection, residents and staff said the atmosphere in the centre had improved and that the person in charge and provider were working to improve the conditions for staff. A consultant had been working with staff to listen to concerns and discuss these with the provider.

The provider had taken action to respond to the expressed needs of staff. Staff numbers had increased since the previous inspection. An additional carer was allocated in the morning to meet the needs of residents. An occupational therapist had been recruited on a full time basis and activity hours had been increased until ten pm daily to work with residents. Staff nurses were also allocated additional hours per month to complete care plans.

*Report compiled by:*

Linda Moore

Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

7 February 2013
Provider's response to inspection report *

<table>
<thead>
<tr>
<th>Centre Name:</th>
<th>Shannagh Bay Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>0095</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>5 February 2013</td>
</tr>
<tr>
<td>Date of response:</td>
<td>28 February 2013</td>
</tr>
</tbody>
</table>

Requirements

These requirements set out the actions that must be taken to meet the requirements of the Health Act 2007, 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.

Theme: Governance, Leadership and Management

**Outcome 4: Records and documentation to be kept at a designated centre**

The provider is failing to comply with a regulatory requirement in the following respect:

The insurance policy on display did not fully meet the requirements of the Regulations.

Many of the operational policies did not guide the practice.

**Action required:**

Put insurance cover in place against loss or damage to the property of residents including liability as specified in Regulation 26 (2).

* The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
**Action required:**

Put in place all of the written and operational policies listed in Schedule 5 of the Regulations.

**Reference:**

Health Act, 2007  
Regulation 27: Operating Policies and Procedures  
Regulation 26: Insurance Cover  
Regulation 21: Provision of Information to Residents  
Standard 29: Management Systems  
Standard 1: Information

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

<table>
<thead>
<tr>
<th>Provider's response:</th>
<th>Timescale:</th>
</tr>
</thead>
</table>
| Insurance; please see attached letter relating to the insurance. As soon as this issue is resolved we will forward all documentation. It is important to note that there is insurance in place, but it does not cover exactly what is in the legislation. Our insurers have told us that such an open-ended policy is not feasible. The Department of Health has been contacted in relation to this and we are awaiting a reply.  
As stated in page 4 of this report, 'all of the policies required in Schedule 5 of the Regulations were in place'  
Policies will be reviewed and the person in charge will ensure that the policies will consistently guide practice. | Awaiting outcome from Dept. of Health on-going |

**Theme: Safe care and support**

**Outcome 6: Safeguarding and safety**

The provider is failing to comply with a regulatory requirement in the following respect:

The policy on and procedures for the prevention, detection and response to abuse did not include the procedures to be followed when investigating an allegation of elder abuse.

**Action required:**

Put in place a policy on and procedures for the prevention, detection and response to abuse.
### Please state the actions you have taken or are planning to take with timescales:

<table>
<thead>
<tr>
<th>Provider's response:</th>
<th>Timescale:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The policy on Prevention, Detection and Response to abuse will be reviewed to ensure it includes comprehensive details on the procedure to be followed when investigating an allegation of abuse. The policy will then be fully implemented</td>
<td>30/04/13</td>
</tr>
</tbody>
</table>

### Outcome 5: Health and safety and risk management

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

The risk management policy had not been fully implemented.

While there were systems for the assessment of non clinical risk, these had not included all risk and had not identified ways to manage such risks, including risks such as the lack of sinks available to staff for hand hygiene, lack of a call bell in the conservatory, smoking risk and infection control risks due to the arrangements for the cleaning room.

**Action required:**

Put in place a comprehensive written risk management policy and implement this throughout the designated centre.

**Action required:**

Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

### Reference:

Health Act, 2007
Regulation 31: Risk Management Procedures
Standard 26: Health and Safety
Standard 29: Management Systems
Please state the actions you have taken or are planning to take with timescales:

<table>
<thead>
<tr>
<th>Provider’s response:</th>
<th>Timescale:</th>
</tr>
</thead>
<tbody>
<tr>
<td>We were pleased with your comment in the report that stated ‘ the inspector found that practice generally in relation to the health and safety of the residents and the management of risk promoted the safety of the residents, staff and visitors‘, this is hugely important to our overall care of the residents and the well-being of our staff.</td>
<td></td>
</tr>
<tr>
<td>The person in charge will ensure that the revised Risk Management policy will be fully implemented.</td>
<td>30/04/13</td>
</tr>
<tr>
<td>A risk assessment has now been carried out in relation to all residents who smoke and a care plan put in place to ensure their continuing safety.</td>
<td>completed</td>
</tr>
<tr>
<td>A call bell has been ordered for the conservatory and we are awaiting delivery.</td>
<td>awaiting delivery</td>
</tr>
<tr>
<td>Work on the risk register is on-going.</td>
<td>on-going</td>
</tr>
<tr>
<td>Standard practice will now include both the Physiotherapist and the Occupational Therapist reviewing all residents post falls.</td>
<td>completed</td>
</tr>
<tr>
<td>The issue relating to limited access to hand-washing facilities for staff will be addressed once the new building is in place - in the meantime there are hand-washing sinks available in all bedrooms with hand-gels and paper towels - so each person using the current facilities will use single use items (hand gels and paper towels) which reduces the risk of any spread of infection.</td>
<td>New build approx completion date November 2014</td>
</tr>
<tr>
<td>Also the issue relating to the cleaners room will be addressed in the new building - but we must point out at this stage that we do not have any issues with infection control.</td>
<td>New build approx completion date November 2014</td>
</tr>
</tbody>
</table>

The provider is failing to comply with a regulatory requirement in the following respect:

There was no record that emergency lighting was routinely checked or serviced.

Action Required:

Make adequate arrangements for the maintenance of all fire equipment.
Reference:
Health Act, 2007
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety

<table>
<thead>
<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
<th>Timescale:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider's response:</td>
<td>completed</td>
</tr>
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</table>

As stated in the report the entire emergency lighting system has been replaced since the previous inspection, this was commissioned on 24/09/12 and was then serviced on the 20/12/12. The service log was available on the day but the inspector required a more detailed log which has now been but in place by the contractors.
All documentation is now available in the nursing home and will be forwarded with this action plan.

Outcome 8: Medication management

The provider is failing to comply with a regulatory requirement in the following respect:

Nurses were administering medications in crushed format which had not been individually prescribed for this, contrary to their professional guidelines.

Nurses were still not recording the administration of all medications adequately. The dosage of insulin that they administered to residents was not always recorded on the administration record and they often left the administration record blank when insulin was not required.

Action required:

Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

Reference:
Health Act, 2007
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

| Please state the actions you have taken or are planning to take with timescales: | Timescale: |
Provider’s response:

The Medication Management Policy has been reviewed and the person in charge will ensure full compliance with the policy, current guidelines and legislation.

Any resident who requires their medications to be crushed will have this signed by their GP and confirmed by The Pharmacist that the individual medications are suitable to crush.

All Nurses are now aware that blank spaces must not be left on the administration records - if no insulin is due as per sliding scale it will be recorded as such.

**completed**

**completed**

**completed**

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**Theme: Effective care and support**

**Outcome 11: Health and social care needs**

**The person in charge is failing to comply with a regulatory requirement in the following respect:**

Care plans did not include the identified needs of some residents and did not provide clear and adequate guidance for staff to deliver care.

Care plans were not developed in consultation with the residents.

**Action required:**

Set out each resident’s needs in an individual care plan developed and agreed with the resident.

**Reference:**

- Health Act, 2007
- Regulation 8: Assessment and Care Plan
- Standard 10: Assessment
- Standard 11: The Resident's Care Plan
- Standard 13: Healthcare

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

**Provider's response:**

Care plans will always be a work in progress.

All staff nurses are allocated a certain number of residents and they will set up meetings with the residents and/or families to consult on the care plans. These meetings will be scheduled for a time that suits the resident and/or their family during the months

**Timescale:**

- on-going
- 30/04/13
of March and April

Additional work will be done to improve the quality of the care plans relating to residents who present with behaviours that challenge, use of restraint and falls prevention.  

<table>
<thead>
<tr>
<th>The provider has failed to comply with a regulatory requirement in the following respect:</th>
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<tbody>
<tr>
<td>Restraint, behaviour that is challenging and falls were not managed effectively to ensure the safety of residents.</td>
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<tr>
<th>Action required:</th>
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<tr>
<td>Provide a high standard of evidence based nursing practice.</td>
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<table>
<thead>
<tr>
<th>Reference:</th>
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</thead>
</table>
| Health Act, 2007  
Regulation 6: General Welfare and Protection  
Standard 21: Responding to Behaviour that is Challenging |

<table>
<thead>
<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
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</thead>
<tbody>
<tr>
<td>Provider’s response:</td>
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<tr>
<td>The person in charge will again review the policies on restraint, falls management and management of behaviours that challenge and will ensure that the policies are fully implemented.</td>
</tr>
<tr>
<td>A comprehensive neurological chart and pen torch are now readily available to all nurses to ensure that any resident with who may have banged their head while falling will be monitored and all findings documented.</td>
</tr>
<tr>
<td>The person in charge will continue to monitor the implementation of these policies through the weekly nurse's meetings.</td>
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<tr>
<td>The outcomes of the nurse's meeting will be passed on to all staff at the shift handover meetings both morning and evening.</td>
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<th>Timescale:</th>
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| 30/04/13  
completed  
on-going  
on-going |

<table>
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<tr>
<th>Outcome 12: Safe and suitable premises</th>
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<tbody>
<tr>
<td>The provider is failing to comply with a regulatory requirement in the following respect:</td>
</tr>
<tr>
<td>There was a shortage of assisted toilets and showers for residents’ use.</td>
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</table>
There was a lack of storage space; therefore equipment was stored in bathrooms and on the corridors.

There were inappropriate changing facilities for staff which was an infection control risk.

The basement area was in a poor state of repair.

There was poor ventilation and there was a foul odour coming from some of the chairs.

There was no access to secure outside space for residents.

**Action required:**

Provide sufficient numbers of toilets, and wash-basins, baths and showers fitted with a hot and cold water supply, which incorporates thermostatic control valves or other suitable anti-scalding protection, at appropriate places in the premises.

Provide a sufficient number of toilets which are designed to provide access for residents in wheelchairs, having regard to the number of residents using wheelchairs in the designated centre.

**Action required:**

Ensure the premises are of sound construction and kept in a good state of repair externally and internally.

**Action required:**

Keep all parts of the designated centre clean and suitably decorated.

**Action required:**

Provide and maintain external grounds which are suitable for, and safe for use by residents.

**Action required:**

Provide suitable ventilation in all parts of the designated centre.

**Action required:**

Provide suitable changing and storage facilities for staff.

**Reference:**

Health Act, 2007
Regulation 19: Premises
Standard 25: Physical Environment
<table>
<thead>
<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
<th>Timescale:</th>
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<tbody>
<tr>
<td><strong>Provider’s response:</strong></td>
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<tr>
<td>1. As stated in the report two new assisted bathroom suites have been installed since the last inspection. These are also fitted with anti-scaling protection. The bathrooms have been a huge benefit to the residents and the staff who assist them. Further assisted toilets and showers will be added in the planned new building and the refurbishment of the current building.</td>
<td>New Build approx completion date November 2014</td>
</tr>
<tr>
<td></td>
<td>on-going and planned new build</td>
</tr>
<tr>
<td>2. A rolling programme of maintenance exists with regard to the bedrooms, social rooms, corridors and utility spaces. All outstanding issues like the small tear in the carpet will be addressed in the refurbishment programme scheduled to coincide with the new building - it would be a misuse of resources to replace a carpet now due to a tear when it will be replaced again next year</td>
<td>on-going</td>
</tr>
<tr>
<td>3. All areas of the nursing home are cleaned each day and a schedule of special cleaning is carried out weekly. All areas of the nursing home are decorated as required</td>
<td>approx completion date November 2014</td>
</tr>
<tr>
<td>4. Currently there are no external grounds available on site but this will be addressed in the planned new building. In the meantime residents are accompanied for walks on Bray promenade and seafront, daily/when weather permits</td>
<td>approx completion date November 2014</td>
</tr>
<tr>
<td>5. Ventilation will be addressed when the new building is completed and the present building will be renovated.</td>
<td>New cushions within 10 days</td>
</tr>
<tr>
<td>In relation to the foul odour coming from the chairs we explained to the inspector on the day that we had identified this problem and had lodged a complaint with the company in October 2012, which we were actively following up. The chairs had been purchased in December 2011 and were sold to us as being water resistant but this quite clearly was not the case. We are pleased to report that since the inspection the company have now come back and admitted that there is a fault in the fabric and they will replace all the chairs. In the meantime they have agreed to replace all cushions on the chairs so this should eliminate the odour immediately. Also a very intensive daily cleaning programme for the chairs has been put in place to ensure the odour is no longer an issue.</td>
<td>Replacement chairs- awaiting company to confirm date</td>
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</table>
6. Included in the plans for the new building and refurbishment of current building is a changing room and rest room for the staff which will include individual lockers to safely store all their personal items during working hours.

<table>
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<tr>
<th>Theme: Person-centred care and support</th>
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<tr>
<td><strong>Outcome 16: Residents’ rights, dignity and consultation</strong></td>
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<tr>
<td>The provider is failing to comply with a regulatory requirement in the following respect:</td>
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<tr>
<td>Mobile screening was still inappropriate and did not provide adequate screening for many residents in shared rooms when personal care was being delivered.</td>
</tr>
<tr>
<td>Residents accessed other residents’ bedrooms to have a shower or use the assisted toilet which impacted on the privacy of other residents.</td>
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<tr>
<td><strong>Action required:</strong></td>
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<tr>
<td>Provide residents with privacy to the extent that each resident is able to undertake personal activities in private.</td>
</tr>
<tr>
<td><strong>Reference:</strong></td>
</tr>
<tr>
<td>Health Act, 2007</td>
</tr>
<tr>
<td>Regulation 10: Residents’ Rights, Dignity and Consultation</td>
</tr>
<tr>
<td>Standard 4: Privacy and Dignity</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take with timescales:</strong></td>
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<td>Provider’s response:</td>
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<tr>
<td>We have installed fixed curtains between the beds in twin rooms on the 2nd floor and had planned to continue this throughout the house but we have been advised by the suppliers that once these appliances are fixed they cannot be reused when the rooms are reconfigured and as such will be a waste of resources.</td>
</tr>
<tr>
<td>We are currently reviewing the mobile screens with a view to refurbishment. This will then be monitored and staff will be trained to ensure correct use of these screens. Audits will be carried out regularly to ensure the privacy and dignity of the residents will be protected at all times.</td>
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<tr>
<td><strong>Timescale:</strong></td>
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<tr>
<td>approx completion date November 2014</td>
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<td>30/04/13</td>
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### Theme: Workforce

#### Outcome 18: Suitable staffing

**The person in charge is failing to comply with a regulatory requirement in the following respect:**

There was no assessment of the staffing needs to support residents during tea time.

**Action required:**

Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

**Reference:**

- Health Act, 2007
- Regulation 16: Staffing
- Standard 23: Staffing Levels and Qualifications

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

<table>
<thead>
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<th>Provider’s response:</th>
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<tr>
<td>The inspector noted in the report on page 12 '....that there was sufficient staff on duty to meet the needs of the residents....' We accept that there may have been an issue around the organisation of the staff and this has now been addressed and all communal areas are supervised throughout the day. This will be audited on a regular basis to ensure the residents are supervised at all times. At tea-time each day there are 6 care assistants, two staff nurses and an activities person to supervise a maximum of 44 residents, this is a ratio of 4.8:1, following a risk assessment, we feel this is adequate staff to ensure supervision of the residents. (This does not take into account other staff on duty at this time such as kitchen staff laundry or domestic etc.)</td>
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Provider's response:

We were very glad to welcome the inspector back to Shannagh Bay and thank her for her assistance and constructive comments which can only help us to improve our services.

We were delighted to see that the inspector noted an improved atmosphere in the nursing home as this had been having a negative effect on everyone. Considerable effort has gone into achieving this outcome by all concerned so it great to see that it has been worthwhile.

Provider’s name: Pauline Smith  
Date: 06/03/2013