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:	25 April 2025
Centre ID:	OSV-0000383
Fieldwork ID:	MON-0046900

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:	28

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
Friday 25 April 2025	09:00hrs to 17:00hrs	Sarah Armstrong	Lead
Friday 25 April 2025	09:00hrs to 17:00hrs	Michael Dunne	Support

What residents told us and what inspectors observed

All residents spoken with provided inspectors with positive feedback about the care and support that they were receiving in the centre. One resident told inspectors that "I'm being well looked after" and "I can't speak highly enough of the staff". Another told inspectors "I'm very happy here".

Staff supported residents to exercise choice and autonomy in how they lived their days in the centre. One resident told staff that they enjoyed living in the centre because they could "go to bed and get up at the times I like". The provider had also arranged for residents to attend a safeguarding training course following some residents expressing an interest in learning about safeguarding.

After an introductory meeting with the clinical nurse manager, inspectors completed a walk around of the centre. Shannon Lodge Nursing Home is situated in the village of Rooskey, Co. Roscommon. The designated centre is registered to accommodate a maximum of 36 residents. Residents' accommodation is located on the ground floor of the building and includes a mix of single and twin occupancy bedrooms, all with full en-suite facilities. The corridors in the centre were wide and fitted with hand rails on both sides to support residents to mobilise safely and independently. The centre was furnished to a homely standard with plenty of artwork. There was an abundance of old style and antique memorabilia displayed throughout, including cameras, televisions and crockery. A wall in the dining room displayed a large mural of an old cottage fireplace, which provided an opportunity for residents to enjoy and reminisce.

The bedrooms were suitably furnished to meet residents' needs and were personalised with residents' own belongings including photographs, ornaments and soft furnishings. There were two spacious day rooms with plenty of comfortable seating for residents to sit and relax. Both rooms were well-lit by natural light and contained old-style furniture, including bookshelves and a grandfather clock. There was an accessible and secure outdoor garden area for residents to enjoy. The outdoor area was nicely decorated with a pergola and raised flower beds with colourful plants. There was also a water feature and seating available for residents to relax in the outdoors. Notwithstanding the homely feel of the centre, inspectors found that some areas were in disrepair and required refurbishment or minor repairs, such as frayed carpet in common areas, and some toilet facilities required refurbishment particularly in respect of the grab rails and storage facilities. Other areas of the centre were found to be visibly unclean and inspectors found that storage in the centre was limited due to the loss of an outdoor storage space to facilitate the commencement of building works on the grounds of the centre.

Staff spoken with on the day were knowledgeable of the residents and their individual needs and were highly complementary of the support and communication they receive from the management team on an ongoing basis. One staff member told inspectors that Shannon Lodge Nursing Home was a "lovely place to work".

Inspectors found this to be reflected in the calm and relaxed atmosphere on the day of inspection. Staff and residents appeared to know each other well and all interactions between residents and staff that inspectors observed were considerate and respectful. Staff were seen to be providing timely and discreet assistance to residents as required, which supported residents to maintain their dignity and independence. Interactions between members of the staff team were also professional and cordial which added to the warm atmosphere in the centre.

Inspectors observed residents spending time in communal areas and in their own bedrooms on the day of inspection. The centre has a dedicated activities staff member and there is a strong focus on meaningful social activities for residents, taking into account their interests and capacities. Inspectors observed several activities provided on the day, which included newspaper reading, exercise and music. Residents who were in their bedrooms told inspectors that this was their preference which was respected by staff, and these residents had access to other means of entertainment including televisions, newspapers and books.

Residents' meal time experience was found to be very positive. Dining tables were nicely set, with flowers, menus and condiments present. Menus included photographs of the meals to aid those residents who may have difficulties reading the meal descriptions to understand the options available to them. Residents had choice at meal times. Inspectors observed the food to be well presented and appealing to eat. Residents spoken with told inspectors that the food was "too good" and that "there is always something I like on the menu". Catering staff informed inspectors that if a resident did not wish to have what was on the menu, or where a resident may have alternative dietary requirements that this would be respected and an alternative option would be made available to them. Residents who required assistance at meal times were observed to be receiving discreet assistance from staff.

The next two sections of the report set out the findings of this inspection in relation to the governance and management arrangements in place and how these arrangements impacted on the quality and safety of the service being delivered to residents.

Capacity and capability

Overall, this was a well-managed centre which ensured that residents were provided with good standards of care to meet their assessed needs. Although there were management systems in place to maintain these standards, inspectors found a decline in the levels of oversight since the last inspection in May 2024. Systems to promote residents' safety were weak as described under the regulations. There was a poor appreciation of risk which meant that some risks were not known to the provider, and therefore there were no action plans in place to mitigate or reduce these risks.

This was an unannounced inspection conducted by inspectors of social services to assess compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulation 2013 (as amended). The inspectors also followed up on the compliance plan from the inspection held in May 2024 and found that the provider had implemented the compliance plan in relation to staff training.

The registered provider of this designated centre is Shannon Lodge Nursing Home Rooskey Limited. The provider is represented by one of the company directors. The person in charge of the centre has worked in the role since 2007 and meets the requirements of Regulation 14: Persons in Charge. They are supported in their role by a clinical nurse manager and by a team of nursing staff, health care assistants, hospitality and catering staff. Activity, administration and maintenance personnel also make up the staffing compliment.

There was evidence of regular governance and oversight of the centre with clinical governance meetings held on a regular basis. These meetings reviewed key areas of the service such as human resources, complaints, policies and procedures, incidents, audits and key performance indicators were also discussed and monitored. However, on the basis of the evidence found on this inspection, the levels of oversight and scrutiny currently in place were not effective, and therefore the quality of the information collected through the current quality assurance processes did not provide sufficient assurance that this service was safe, consistent, and appropriate.

There was a statement of purpose that had been updated to include the changes to the legislation in relation to Regulation 34. The statement of purpose included the information required under Schedule 1 of the regulations. The inspectors found that there were appropriate numbers of nursing and care staff numbers to meet the assessed needs of residents and ensure the delivery of the service. A review of the rosters confirmed that there is one nursing staff available at all times in the centre. Staff cover for vacant positions on the roster were covered using existing staff resources.

There was a well-organised staff training programme in place which incorporated a selection of both face to face and online training. Records confirmed that all staff were up to date with their mandatory training in safeguarding, fire safety and manual handling.

The inspectors met several staff members in the course of the day who had worked in the centre for a number of years, and all reported that this nursing home is a very homely place to work. Staff members added that there is regular support from the management team who were supportive of them in their roles. Staff confirmed that there was effective communication within the team and that they attended handover.

There was evidence that the majority of records were well-maintained, secure, and were updated on a regular basis. However, records relating to residents' dietary requirements were found in an unlocked cupboard which meant that they were not secure. All records requested were made available for inspectors to review. A focus

on records relating to Schedule 2 of the regulations found that staff had the required documentation in place prior to commencing employment in the designated centre.

The provider maintained a policy and procedure on complaints. Records confirmed that the provider investigated complaints in line with this policy. Four complaints were recorded since the last inspection and all were seen to be resolved within the specified timescale as outlined in the complaints policy. The provider was keen to learn from complaints and to identify patterns that may impact on the quality of the service provided.

Regulation 15: Staffing

There were sufficient numbers of staff on duty to meet the assessed needs of the residents. Both planned and worked rosters were reviewed, and records showed that staffing levels were maintained in all departments. Gaps on the rosters were covered by the centres own staff working additional hours.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had ensured that staff have access to appropriate training. All staff had completed mandatory training in fire safety, safeguarding and moving and handling. A sample of four staff files were reviewed and all were found to meet the requirements of Schedule 2. There was a robust induction programme for new staff who had joined the company.

Judgment: Compliant

Regulation 21: Records

Records relating to residents' assessed dietary requirements were not stored securely. This was evidenced by:

- Inspectors found residents' nutritional records stored in an unlocked cupboard.

In addition:

- Records describing the whole time equivalents for staff were not accurate as one nursing position which was a part-time role was recorded as a full-time position.

Judgment: Substantially compliant

Regulation 23: Governance and management

The oversight and management of risk did not ensure that the service provided was safe, appropriate, consistent and effectively monitored. Consequently, there were poor systems in place to identify, manage and respond to risk. This was evidenced by;

- Risks associated with infection prevention and control were not well managed by the provider.
- Current processes to effectively manage infection control were weak.
- Suitable arrangements to address the reduction in storage facilities were not put in place.
- The oversight of cleaning processes was not effective.
- Inadequate oversight of record management. For example, systems to protect residents' nutritional records were not in place and fire safety records to include fire drills did not identify where improvement was needed.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had prepared a statement of purpose which was available for inspectors to review, and contained the information as required under Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

Records showed that where a notifiable incident occurred these were notified to the Chief Inspector within the required time frames. All quarterly reports were submitted within the required time frames.

Judgment: Compliant

Regulation 34: Complaints procedure

There was an accessible complaints policy and procedure in place to facilitate residents and or their family members to lodge a formal complaint, should they wish to do so. The policy clearly described the steps to be taken in order to register a formal complaint. This policy also identified details of the complaints officer, timescales for a complaint to be investigated and details on the appeal process should the complainant be unhappy with the investigation conclusion.

A review of the complaints log indicated that the provider had received four complaints since the last inspection in May 2024. Records confirmed that the complaints received were processed in line with the centre's complaints policy.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had failed to fully implement policies and procedures relating to infection control and risk management. These findings are reflected under Regulation 27: Infection control and Regulation 23: Governance and management.

Judgment: Substantially compliant

Quality and safety

Overall, inspectors found that this was a good service. A dedicated staff team promoted the care and well-being of residents through person-centred care and support. Residents were supported to live full and meaningful lives in the centre and had the autonomy to choose how they carried out their days. However, significant non compliances were found under infection control and the oversight of risk. In addition, the lack of available storage space, and usage of existing storage facilities was not appropriate and was contributing to the non compliances found on this inspection.

The staff working in the centre were familiar with the residents' needs and residents were receiving good standards of nursing care and support. Care plan documentation for residents was found to be person-centred and clearly guided staff

to provide care and support that was in line with residents' individual preferences. The provider had ensured that residents had timely access to their general practitioners and other health and social care professionals when required, for example, speech and language therapist, tissue viability nurse and chiropodist. Through a review of a sample of residents' care plans, inspectors found that recommendations from residents' medical and health and social care professionals were accurately integrated into the residents' care plans to inform good quality care provision.

Residents had access to a variety of social activities. An activity schedule was displayed in the centre, and on the day of inspection residents were seen to be participating in meaningful activities which were aligned to their interests and capacities. The registered provider had also organised a "well-being week" for residents with different activities taking place as part of this event. On the day of inspection, inspectors observed residents enjoying a range of activities including exercises and music. There were Easter decorations displayed in one of the sitting rooms which residents had recently participated in making with support from the activities coordinator.

There was evidence that residents were supported to participate in the organisation of the centre, with resident meetings held regularly. Inspectors found that recommendations from residents' meetings had been put into practice in the centre.

Staff were attentive to the needs of residents during meal times and the meal-time experience for residents in the centre appeared natural and relaxed. Meals were presented in an appetising manner. There was a good choice of food available for residents across all meals on the day of inspection. Residents requiring assistance with their meals were observed to be in receipt of discreet support from staff which promoted their dignity. Residents who required modified diets were catered for in line with their care plans.

Overall, the premises was laid out in such a way that it met the needs of the residents who lived there. The centre was well-lit and warm with a homely atmosphere. Residents' bedroom accommodation was personalised to residents' own individual tastes, with items such as photographs and ornaments displayed. However, some areas of the centre were found to be visibly unclean. The provider had not ensured that there was effective oversight of cleaning practices in the centre in order to protect residents from the risk of infection. Maintenance records confirmed the provider had requested for the repair of the bedpan washer, this had not been completed at the time of this inspection. Alternative arrangements for the cleaning of bed pans and urine bottles in the interim period were not well-established or clear. This is discussed further under Regulation 27: Infection control.

Inspectors also found there was insufficient storage within the centre. Staff told inspectors that this was as a result of the loss of an outdoor storage space to facilitate building works on the grounds of the centre. This is discussed further under Regulation 17: Premises.

Measures were in place to ensure residents were protected from risk of fire. However, not all measures ensured the effective containment of smoke and fire in the event of a fire emergency in the centre. This is discussed further under Regulation 28: Fire precautions.

Regulation 17: Premises

The premises was designed and laid out to meet the needs of residents. However, the registered provider had not ensured that the premises conformed to all matters set out in Schedule 6. This was evidenced by the following findings;

- Inspectors found that there was insufficient storage in the designated centre. For example, a storage space for residents' mobility equipment was not large enough to store all equipment. This was resulting in hoists being stored on corridors in two areas on the day of inspection. Inspectors also found large amounts of opened incontinence wear being stored inappropriately in areas including the sluice room and communal toilets. Items were also being stored on the floors in some areas including in a cleaners' room, sluice room and an upstairs storage area.
- Sluicing facilities were not appropriate. There was no clinical wash-hand basin in the sluice room, nor was there a clinical waste bin. The bed pan washer was out of order and there was evidence that this had been the case for a number of weeks. There was also no service history available on the machine. Furthermore, the door to the sluice room was unlocked which presented a risk to residents who may enter the area and access hazardous products. It also did not ensure that residents would be protected from risk of infection.
- The cleaners' room did not have an operational sink as there was no supply of piped hot or cold water to the taps.

Judgment: Substantially compliant

Regulation 26: Risk management

There was a risk management policy and procedure which met the requirements of the regulation and was updated in April 2024. Risk assessments described the control measures in place to mitigate the levels of risk identified. However, specific risks identified by the inspectors are highlighted under the relevant regulations related to governance and management, fire precautions, record management and infection control.

Judgment: Compliant

Regulation 27: Infection control

The provider did not ensure that infection prevention and control procedures were consistent with the national standards for infection prevention and control in community services published by the authority.

The environment was not managed in a way that minimised the risk of transmitting a health care-associated infection. This was evidenced by;

- Cleaning schedules in a number of toilets were not correctly maintained. The inspectors observed cleaning checks were signed off as being completed a number of hours ahead of time.
- A number of wash basin water outlets observed throughout the centre were found to have a build-up of grime present.
- There were two staff hand washing sinks situated on the corridor in the centre. These sinks did not meet the specifications of clinical wash-hand basins and therefore did not minimise the risk of cross-contamination.
- There was no clinical wash-hand basin available in the sluice room.
- There was no clinical waste bin present in the sluice room.
- Items were observed to be stored on the floor in a number of areas in the centre including the sluice room, cleaners store room and an upstairs store room. This meant that the flooring in these areas could not be effectively cleaned to minimise the risk of infection.
- Inspectors observed two instances of alcohol hand-gel being decanted into old washing-up liquid bottles. This practice is not in line with infection control guidance.
- Cleaning products in use did not have a date of opening on them and many labels were worn. Therefore it could not be determined how long products were open and if this compromised the effectiveness of their cleaning performance.
- Inspectors observed that waste was not securely contained; a clinical waste bin outside one resident's room during a period of infection was not encased and the clinical waste bag was exposed.
- Tiled walls in a number of areas, including the sluice room and resident toilets contained holes from previous wall fixings. In addition, flooring was observed to be damaged in some areas, including within a linen store. This meant that these surfaces could not be effectively cleaned.
- A wash hand basin in the cleaner's room was not functioning and therefore did not promote good hand hygiene practices.

Equipment and supplies were not consistently decontaminated and maintained to minimise the risk of transmitting a health care-associated infection. This was evidenced by the following;

- The system in place to ensure equipment was cleaned between uses was not robust. Inspectors observed residents' assistive equipment stored in a

readiness for use area to be visibly unclean with dust and debris and in some cases soiled with food.

- Grab rails in a number of toilets were found to be visibly unclean with evidence of dust and debris. Furthermore, a number of grab rails were also rusted and the paint was chipped in places meaning that they could not be effectively cleaned.
- There was no functioning bed pan washer available in the centre. Despite no current needs to utilise the bed pan washer and efforts being made by the provider to organise repairs to the machine ongoing since March, there was no interim contingency plan in place in the event that this equipment should be needed.
- Cleaning equipment was observed to be unclean. For example, a floor buffer stored in the cleaner's room had a significant build-up of dust and debris present on it and therefore presented a risk of contamination. Dusters stored in the cleaner's room were also visibly unclean.
- There was a significant number of hoist slings stored in one of the storage areas which were not labelled with individual residents' names. Therefore, the inspectors were not assured that residents requiring a hoist to assist with mobilising were always provided with their own individual sling to reduce the risk of infection.

Judgment: Not compliant

Regulation 28: Fire precautions

Although the provider had put measures in place to protect residents from risk of fire, further actions were necessary to ensure residents' safety and compliance with Regulation 28: Fire precautions;

- Three oxygen cylinders were inappropriately stored in an unsecured area with no signage indicating that oxygen was being stored in that area. The cylinders were also stored alongside combustible materials. An immediate action was issued to the provider to address the issue and actions were taken by the provider on the day.
- A number of cross-corridor fire doors tested by inspectors were found to have gaps when closed. This did not ensure that smoke and fire would be effectively contained in the event of a fire.
- The door to the sluice room had gaps at the keyhole which also did not ensure effective containment of fire and smoke in the event of fire.
- Although illuminated exit signs were available at the points of exit, directional signage was not installed along corridors to guide residents and staff to these exits.
- Some electrical equipment, including an oxygen concentrator and a hoist, were found not to have up to date PAT testing carried out.
- Records of a fire drill conducted on 20 February 2025 were not fully completed. For example, there were no details of where residents were

evacuated to, or the time it took to complete the evacuation of the compartment. Furthermore, there was no time bound action plan put in place to address issues identified during the drill.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors found that residents' needs were regularly assessed and the information within residents' care plans was up to date and sufficiently detailed to guide staff in delivering safe and good quality care. Risk assessments were completed in response to incidents or changes in residents' conditions and these assessments were were used to inform the residents' care plans. Recommendations from medical and health and social care professionals were also observed to be included within residents' care plans.

Judgment: Compliant

Regulation 6: Health care

Inspectors found that residents had timely access to both medical and health and social care professionals. Arrangements were in place for out-of-hours medical support for residents in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider had provided residents with adequate facilities for occupation and recreation. Residents had good opportunities to participate in activities and consideration had been given to residents' interests and capacities when planning activities. Residents had access to radio, television and newspapers and were consulted about and participated in the organisation of the designated 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	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Shannon Lodge Nursing Home OSV-0000383

Inspection ID: MON-0046900

Date of inspection: 25/04/2025

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: A Full audit of operational logs to identify gaps have been completed and areas of improvement have been identified Cleaning schedules reviewed and clear procedures have been introduced for documentation standards, file maintenance in respect to the kitchen nutritional logs and secure storage is now in place. Staff have received updated training on record keeping, documentation timelines and the importance of accurate records. Particularly in relation to staff signing on items and areas of where cleaning as taken place. A role for a cleaning/ housekeeping supervisor has been advertised to ensure oversight and accountability is identified in a timely manner A 4 monthly internal audit schedule has been established to ensure ongoing compliance and identify any lapses going forward. Statement of Purpose has been updated with current whole-time equivalents.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The live risk register has been reviewed, and all emerging risks are recorded, PIC looks at overall risk oversight and reporting, Clinical nurse manger/ Staff nurse oversees operational risk and the monitoring of same, staff nurse/HCA/housekeeping/ maintenance/Kitchen staff. The clinical nurse manager monitors the register and ensures risks are reviewed and actioned. All staff informed on identifying day to day risks and properly escalating and recording	

when equipment needs to replace / service
This will be reviewed and rated monthly by management /maintenance to ensure transparency and follow through is completed.
Sluice Machine is fully working and operational following inspection. The policy has been reviewed and updated and all staff informed, the Service contract is updated
As stated in the Regulation 21, the areas of record management have been addressed/ identified and clear systems in relation to cleaning of equipment. As part of management meetings going forward risk review will be discussed in more detail.
Quarterly audits on Environmental checks will be completed and any issues that are flagged will be acted on promptly
As mentioned in Regulation 21 cleaning processes and records have been updated
A full audit of storage areas was completed with maintenance following inspection. A storage and equipment management policy was reviewed. All staff scheduled to receive a brief refresher training on infection prevention standards related to storage.
Unused equipment has been removed from the building which has allowed extra space in the designated storage area for all equipment. Staff are aware to use the designated areas for storing the chairs, hoists, and other equipment.
Shelving units in bathrooms has been completed to ensure storage of incontinence wear is always locked.
Environmental walk arounds every quarter with infection control link nurse/ maintenance/housekeeping will include a checklist on storage compliance
Any issues that are highlighted will be logged in maintenance log and a timeframe of completion identified
There is a fire drill schedule in place which ensure staff are familiar with fire safety and contingency plan in the event of a fire alongside yearly fire training. The provider is the designated lead and coordinates drills and training, Scenarios are always used as examples, On review of drills the Fire lead will ensure more detailed documentation is completed and highlight if and where improvements are to be made
The person in charge will oversee records and address any areas which will require improvement going forward and audit 6 monthly thereafter.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
In Shannonlodge, all scheduled 5 written policies and procedures are reviewed as required and are available for all staff. They are based on evidence-based practice. Supplementary policies are also in place to support specific care needs.
Infection control and risk management policies have been reviewed and updated and contingency plan provided in the event of the sluice machine malfunctioning. A maintenance contract is in place with Miele to ensure regular checks are completed on the servicing of the sluice machine. The updated policies have been communicated with staff to ensure a robust cleaning system is maintained.

Regulation 23, Governance and Management, systems have been reviewed to manage and respond to likely risks. The Registered Provider, PIC and infection Control Link nurse will implement and monitor infection control practices in Shannonlodge in line with the National Standards for Infection Prevention and Control and HPSC Guidelines for Residential Care. Findings of audits by IPC nurse will be used for training and quality improvement in Shannonlodge.

The statement of purpose is updated to include the current whole-time equivalents as required under schedule 1 of regulations.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A maintenance log remains in place and continues to track and prioritize repairs
Storage which has been addressed in regulation 23 above.
Unused equipment has been removed from building to provide more storage for equipment in a safe space.
Storage in relation to continence wear has been completed and off floor rack in place in designated storage area.
Locked storage in place in communal bathrooms
Clinical storage bin now in place
As stated above Sluice machine operational following day of inspection and service contract available. To ensure service and maintenance of same is yearly as per contract, given we had logged issue and were awaiting engineer, we have updated sluice policy in relation to same.
Cleaning room has an operational sink in place and is now in working order following inspection
Sluice room remains locked and keypad in operation

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
As mentioned in Regulation 21 cleaning processes and records have been updated
A full audit of storage areas was completed with maintenance following inspection. A storage and equipment management policy reviewed. All staff scheduled to receive a brief refresher training on infection prevention standards related to storage.
The two wash hand basins which were sensor non touch have been replaced with clinical

wash hand basin as per regulations. A clinical wash hand basin has been ordered for the sluice room.
Clinical waste bins are replaced with fully covered bins
Off floor racks in place for continence wear in designated storage
Cleaning products are all dated upon opening and remain in locked storage room
Housekeeping staff have been educated on the correct replacement of alcohol gel dispensers refills. Following an audit conducted on hand sanitizer dispensers, new automated hand sanitizer dispensers will be replaced on Friday, July 18th 2025. The responsibility will be with housekeeping staff to restock and replace with a new refill container and overseen by the clinical nurse manager to ensure the correct practice is upheld.
A refurbishment plan re-updating rooms and flooring is in place.
In relation to equipment i.e. the buffer, it is operational but old, which was evident to see, this is replaced with a newer model which can be cleaned in line with infection control guidelines
The residents equipment cleaning schedule and deep cleaning schedule has been reviewed and is updated. A new clinell clean tagging system is introduced to ensure staff can easily identify cleaned or contaminated equipment that needs cleaning prior to use with a resident.
An audit of grab rails is under review and will be replaced in accordance with refurnishing plan
All residents always carry their own individual slings and this is reflected in residents, the extra slings have now been removed.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Storage of Oxygen Cylinders
We acknowledge that three oxygen cylinders were stored inappropriately in an unsecured area. Immediate actions were taken on the day of inspection to remove the cylinders, secure their storage in a designated, ventilated medical gases store, and install clear warning signage. A check system has been implemented to ensure ongoing compliance.
Cross-Corridor Fire Doors
Following the identification of gaps in a number of cross-corridor fire doors, we have arranged for a qualified fire door contractor to carry out remedial works to restore full integrity. All fire doors will be inspected, and certification of compliance will be provided upon completion. Interim measures, including increased monitoring and regular checks by maintenance, are in place.
Sluice Room Door Gaps
We have scheduled remedial work to address the gaps at the keyhole of the sluice room door to ensure effective smoke and fire containment. This work has now been completed.
Directional Signage Along Corridors

Directional fire exit signage has been ordered and is now fitted along the middle corridors to guide residents and staff to the nearest exits. This is now completed.
PAT Testing of Electrical Equipment
We confirm that PAT testing of the oxygen concentrator and hoist has since been carried out, and all other electrical equipment has been reviewed to ensure records are current. A system has been put in place to maintain up-to-date testing records and ensure no equipment is overlooked.
Fire Drill Records
The fire drill record of 20 February 2025 has been reviewed, and the missing details have been documented. Going forward, all fire drill records will include:
o Time taken to evacuate the compartment
o The final evacuation location
o A clear, time-bound action plan to address any identified issues
We are committed to maintaining the highest standards of fire safety and compliance.

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 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/05/2025
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	15/05/2025
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	11/07/2025
Regulation 27(a)	The registered provider shall ensure that	Not Compliant	Orange	21/07/2025

	infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	10/06/2025
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	29/08/2025