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:	Talbot Lodge Nursing Home
Name of provider:	Knegare Nursing Home Holdings Ltd
Address of centre:	17 Kinsealy Lane, Malahide, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	10 July 2024
Centre ID:	OSV-0000182
Fieldwork ID:	MON-0043950

About the designated centre

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

The Talbot Lodge nursing home is situated in a quiet, tranquil setting near the bustling town of Malahide and set in spacious grounds and landscaped gardens which help to provide a homely and cheerful environment. The centre is a single-storey building divided into four areas named Castle, Estuary B, Estuary C and Seabury. The designated centre is registered to provide 24-hour nursing care to up to 103 residents of all dependency levels, male and female, who require long-term and short-term care that includes transitional, convalescence and respite care. The nursing home is currently being refurbished. There are a number of communal facilities available for the residents, including six sitting rooms, three dining rooms, one activity room, a large Café, an oratory and a hairdresser facility. The stated philosophy of care is to provide a person-centred approach, empowering and supporting residents to be as independent as possible and to live meaningful and fulfilling lives.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	76

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
Wednesday 10 July 2024	08:45hrs to 17:30hrs	Sheila McKevitt	Lead
Wednesday 10 July 2024	08:45hrs to 17:30hrs	Manuela Cristea	Support

What residents told us and what inspectors observed

Overall inspectors observed a relaxed and happy environment. Residents told inspectors they were satisfied with the care they received and they felt supported to lead a good quality of life in the centre.

Inspectors walked around the centre with a senior health care assistant recently promoted to a supervisory role and a member of the senior management team. They spoke with residents as they went about their daily lives. From interactions with residents and observations made on the day, it was evident that most residents were happy living in Talbot Lodge Nursing Home and that over all it was a homely and comfortable place to live, albeit a number of bedrooms required upgrading.

The corridors were free from clutter and inspectors found that communal rooms and occupied bedrooms for the most part were clean and tidy and in an improved state of repair. However, some bedrooms on both Estuary C and Castle Unit remained in a poor state of repair, some had been partially re-decorated and others had not been decorated to date, the latter bedrooms were mainly in Castle Unit. The visitor of one resident in the Castle unit said that the environment 'appeared tired, depressing looking' and that management were slow to upgrade the bedrooms, they went on to state that they had purchased new curtains for the bedroom as the ones available were not in good condition.

Inspectors observed that some of the minor fire works had been completed, however there was no risk assessment to inform a time bound schedule for the outstanding fire safety works to be completed, as outlined in the scope of works document given to inspectors. This is further discussed under regulation 28: Fire precautions.

Residents had access to a timetable of activities which were facilitated by a team of activity staff. Inspectors observed approximately 12 residents participating in an afternoon bingo session, residents were engaged and appeared to be having lots of fun. Residents said the choice of activities was really good and they enjoyed the variety of activities available to them including yoga classes and coffee mornings.

Residents spoken with were positive about the way they were looked after and the efforts that staff made to ensure that they had everything they needed. A comfortable familiarity was seen to exist between residents and members of staff. Residents spoken with said they currently had no complaints and that when they had, they reported them and they got dealt with promptly to their satisfaction.

There were no restrictions on visitors, which visitors were happy about. They said they signed the visitors book on entry into the centre and explained how they could visit their loved one in the privacy of their bedroom, the sitting room or in the visitors room.

Inspectors observed prescribed medications being stored in an area although secure, it could and was being used as an access point for staff across all disciplines, which meant that it was not safely stored.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

Talbot Lodge Nursing Home is operated by Knegare Nursing Home Holdings Limited and is registered to accommodate 103 residents, with 76 accommodated on the day of inspection. The findings of this inspection were that the registered provider had put management systems in place to ensure that the service provided was safer and the care and welfare needs of the residents were met. The inspectors noted improvements under some of the regulations and this was evidenced by the fact that the provider had come into either compliance or substantial compliance with Regulation 8: Protection, Regulation 27: Infection Control and Regulation 23: Governance and Management. However, Regulation 17: Premises and Regulation 28: Fire Precautions remained non-compliant.

This was an unannounced inspection the purpose of which was to assess compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and follow up on the actions taken by the provider to address significant issues of non-compliance identified during the previous inspection in April 2024. The inspection was also to review representation submitted by the registered provider following the issuing of a notice of proposed decision to stop admissions.

The Chief Inspector had proposed to add a condition that no new resident is admitted to the designated centre until such time that all residents are accommodated in bedrooms that comply with regulatory requirements and the registered provider demonstrates improved and sustained regulatory compliance in respect of:

- Regulation 8: Protection
- Regulation 17: Premises
- Regulation 23: Governance and Management.
- Regulation 27: Infection Control
- Regulation 28: Fire Precautions

The governance and management team had stabilised. This had resulted in some improvements in the overall governance of the centre. Monitoring systems had been established but needed to be reviewed to ensure the oversight of the some areas of practice was strengthened. These areas included: the premises, fire safety,

medication management and assessments and care plans.

Staffing levels were adequate to ensure the assessed needs of residents were met.

Residents' monies was now being managed in a safe and secure manner. The processes in place reflected the centre's policy.

Documents reviewed including the staff roster and statement of purpose reflected legislative requirements. However, a number of Schedule 5 policies were not followed in practice, for example medication management policy and fire safety policy.

Notwithstanding the improvements made, there were repeated findings in respect of Regulation 28: Fire Precautions and Regulation 17: Premises. Fire safety and premises improvements had not been progressed in line with assurances submitted in the providers representation. This demonstrated significant concerns in relation to the providers ability to come into compliance with these two regulations within the timeframe set by the provider.

The registered provider was asked to submit a time-bound schedule of works for the outstanding works to be completed in all bedrooms and communal rooms in Estuary C and Castle Unit. They were also requested to submit a risk assessment for the scope of fire works to be completed and a time bound schedule for these works.

Regulation 15: Staffing

There were adequate numbers of staff on duty with appropriate skill-mix to meet the needs of the residents, taking into account the size and layout of the designated centre.

Judgment: Compliant

Regulation 21: Records

The roster shown to inspectors were clear. They reflected what staff were working what hours on the day of inspection.

Residents' records were stored in a safe,secure and accessible manner.

Judgment: Compliant

Regulation 23: Governance and management

The oversight of practice in a number of areas required strengthening, including, maintenance of the interior of the building, fire safety, medication management, assessments and care planning and the management of complaints.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The complaints policy met the legislative requirements. On review of the complaints on file it was noted that a significant number of complaints, although investigated, had not been closed within 30 days as outlined in the updated complaints policy.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Policies and procedures in accordance with Schedule 5 of the regulations were in place and were reviewed regularly. However, the complaints policy, medication management policy and fire safety policy were not implemented in practice.

Judgment: Substantially compliant

Quality and safety

Overall, the inspectors found that the provider was, in general, delivering a good standard of nursing care; however, the gaps in oversight, as mentioned in the Capacity and Capability section, impacted the quality of life for the residents living in the centre. The findings of this inspection are that further action was required in relation to premises, fire safety and assessments and care planning.

Residents were supported to engage in activities that aligned with their interests and capabilities. Residents had access to local and national newspapers, televisions and radios in their bedrooms and in the communal areas. Information regarding advocacy services was displayed in the reception area.

Inspectors observed improvements made to some areas of medication management.

However, further improvements were required in respect of safe storage of medications, as evidenced under Regulation 29.

The inspectors viewed a sample of residents' electronic nursing notes and care plans. There was some evidence of improvements, however further actions were required as evidenced under Regulation 5: Assessments and Care Plans.

Significant improvements continued to be required in respect of premises, and the inspectorate had been engaging with the provider in this respect for a number of years. For example, surfaces and finishes including furniture and flooring in a large number of bedrooms in Castle unit remained worn and as such did not facilitate effective cleaning. The upgrading in Estuary Unit although completed in some areas had not been done to a satisfactory standard.

Inspectors also observed that the inappropriate storage of files and documentation in a store room had been addressed.

Inspectors reviewed arrangements in place to protect residents from the risk of fire at the centre. The bedroom doors no longer had the intumescent strips painted over and the large gaps around the fire door to the cleaners' store in the Castle unit had been addressed. The fire evacuation plans had been updated and there was one displayed on each corridor.

A new scope of fire works had been compiled by an external company and there was little evidence of progress in relation to addressing the fire safety risks identified in the June 2023 fire inspection. This resulted in ongoing non-compliance with Regulation 28: Fire Precautions. For example, inspectors were not assured that the registered provider had taken adequate precautions against the risk of fire, including the containment of fire, the compartmentation of the building, maintaining appropriate means of escape and provision and maintenance of fire doors. These were repeat findings which were initially due to be addressed by 28 February 2024 as per provider's compliance plan. Inspectors were informed that a new comprehensive fire risk assessment was now completed, however this was not available to the inspectors on the day. The inspectors were presented with a scope of works that was not risk-rated and did not identify time bound actions.

Inspectors were assured that appropriate steps had been taken to ensure residents' finances were safeguarded from potential abuse. The inspectors saw evidence that funds collected on behalf of residents were now being lodged into an account for residents' funds only.

The provider had ensured that infection prevention and control procedures were consistent with the *National Standards for Infection Prevention and Control in community settings* published by HIQA. This was evidenced by the improvements in infection prevention and control within the centre, in particular the cleaning and introduction of a cleaning monitoring system which provided assurance.

Regulation 17: Premises

Recurrent findings were identified that required significant further action to ensure the premises conformed to Schedule 6 requirements:

The registered provider had not ensured that the premises were maintained in a good state of repair and up-keep internally. For example;

- A number of bedrooms identified to inspectors as having been re-furbished were not found to be refurbished to a satisfactory standard. For example, some of these bedrooms, had only had one coat of paint on the walls and they required a second coat; some bedroom floors were heavily marked and did not appear clean; the wooden area beneath some wash hand sinks was damaged and exposed and therefore could not be cleaned properly.
- Some bedside lockers and wardrobes in unoccupied bedrooms in Castle unit had not been repaired or replaced, and were not fit for purpose in their current state.
- A number of both twin and single bedrooms on Castle unit had not been re-furbished to date and remained in a poor state. Notwithstanding the commitments given by the provider that they were not admitting into these rooms, these registered bed-spaces did not meet the regulatory requirements.
- Privacy screening in a number of twin rooms did not ensure the privacy of residents. A number did not have any screening around the bed next to the bedroom door.
- The flooring in a number of bathrooms was damaged and this meant that it was unsafe.

Judgment: Not compliant

Regulation 27: Infection control

The infection prevention and control practices were good. Staff spoken with had a good knowledge of infection prevention practices and inspectors saw that additional clinical wash hand sinks had been in stalled and these were accessible to staff.

Judgment: Compliant

Regulation 28: Fire precautions

The revised programme of works had not been progressed to address concerns raised in relation to fire detection, fire containment and fire doors throughout the

centre. The registered provider did not make adequate arrangements for containing fires. Inspectors could not be assured of effective compartmentation within the building, for example, outstanding issues included;

- There was an electrical distribution communications control cabinet situated behind the nurses' station in Estuary B which was open to the evacuation corridor.
- There were no appropriate fire containment measures in place at this cabinet, which posed a significant risk that a fire in this area could prevent residents, staff or visitors from evacuating safely through the exit doors adjacent to the nurses' station.
- Emergency lighting was not in place outside all emergency exit doors.
- There continued to be non-fire-rated hinges and ironmongery on a number of fire doors throughout the centre. This would make them less effective at containing fires.

Fire drills were not being completed at regular intervals despite clear requirements as per local fire safety policy. Inspectors saw one recorded fire drill since the last inspection in April 2024, which was part of a training session. There had been no simulated fire drills to provide assurance that staff could implement the principles of training in practice, and that they had the capability to safely evacuate all residents from one compartment to a nearby place of safety. In addition, there was no evidence that staff had trialled different evacuation scenarios, including of the largest compartment with the lowest numbers of staff available (for example, night time).

The registered provider did not ensure that appropriate arrangements were in place for maintaining and testing of all fire equipment. Weekly and daily fire safety checks were not completed in line with the centre's own fire policy. There were significant gaps in the records evidencing the fire safety checks, or the fire alarm tests and staff were not clear on who was responsible for completing these checks. There was a lack of assurance on the oversight systems for fire safety and provider's own internal monitoring systems had failed to identify this.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Prescribed medications were not stored safely or securely at all times. Inspectors observed several boxes of prescribed oral nutritional supplements and prescribed laxatives and eye drops that were left unattended in the lobby at the back of Estuary B unit.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Improvements in both resident assessments and care plans were required to ensure the assessed needs of each resident were comprehensively met. For example:

- Some residents assessed as having high malnutrition risk scores did not have their weight recorded as frequently as stated in the nutrition policy.
- Residents with an identified wound, did not always have a wound care plan in place.
- Care plans reviewed were not always detailed enough to guide practice, for example, one resident identified as at risk of absconsion stated for 'close monitoring'.
- Many care plans were unnecessarily duplicated and provided conflicting information, which posed a risk that staff would not have the most current information in respect of residents' assessed needs.
- A review of some residents' daily personal care records indicated that this area of care required greater oversight by qualified staff to ensure residents needs were comprehensively met.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Where restraint was used, it was not always evident that alternatives had been trialled, tested and failed prior to the restraint being used. From speaking with staff and from reviewing the care plans they had written it was evident that they did not have a comprehensive understanding of restrictive practices.

Judgment: Substantially compliant

Regulation 8: Protection

The inspectors found that all reasonable measures were taken to protect residents from abuse. The policy in place covered all types of abuse, and it was being implemented in practice. An Garda Siochana (police) vetting disclosures were obtained prior to staff commencing employment. This provided assurances for the protection of residents. Residents' pensions managed by the provider were now being lodged into a bank account for residents only.

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 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Talbot Lodge Nursing Home OSV-0000182

Inspection ID: MON-0043950

Date of inspection: 10/07/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

1. A comprehensive timebound maintenance schedule to regularly inspect and address any issues related to the interior of the building has been implemented following the Inspection. A reporting system has been established for staff to promptly report maintenance concerns. Weekly inspections will be conducted by the local management team and overseen by the Group's Support Services Manager to ensure the building is maintained to a high standard, with any issues rectified swiftly.

2. The management of the fire safety protocol will be monitored by the Maintenance Department and overseen by the Director of Nursing and monthly by the Group's Support Services Manager. Fire Warden training for the Maintenance Department, (scheduled October 11th, 2024) will enhance their ability to oversee fire safety, ensuring that all fire safety equipment is regularly inspected and maintained. Additionally, they will facilitate fire safety induction for all staff and conduct regular fire drills to ensure that both staff and residents are familiar with emergency procedures.

3. Immediately following the inspection, our medication storage procedures were reviewed and updated. All medications for delivery and collection will now be securely handed over to the Senior Nurse on duty, with a signature required for verification. These medications will then be stored in a safe and secure location. This will be monitored frequently by the Senior Management Team.

4. The frequency of audits on resident assessments and care planning have been increased to weekly to ensure they are thorough, accurate, and up-to-date. Care plans will be reviewed regularly to ensure they reflect the current needs of residents. Staff are being provided with additional training on the importance of detailed and consistent care planning. Findings on audits will be discussed at monthly Governance and Management Meetings.

5. The Complaints Policy has been revised to enhance its effectiveness. Going forward, all complaints will be thoroughly investigated, and a response will be provided within 30 days, with the outcome communicated to the complainant. The complainant will then have 10 days to indicate whether they are satisfied with the resolution or wish to appeal. If no response is received within this timeframe, the complaint will be considered closed, and the complainant will be informed accordingly. The designated complaints officer will monitor the handling of complaints, ensuring they are addressed promptly and effectively. Weekly reviews of complaint logs will be conducted by the Director of Nursing to identify any trends and address underlying issues. This will further be discussed at monthly Governance and Management Meetings.

The oversight of practice will be further enhanced by:

Regular reporting mechanisms for each unit has been established, ensuring that senior management is kept informed of any issues and the actions being taken. Monthly Head of Department Meetings will be held to review progress and discuss any areas requiring further attention.

Quarterly reviews of all oversight processes will be conducted to assess their effectiveness. Feedback from staff and residents will be incorporated to continually improve practices in key areas.

All staff are encouraged to take ownership of their roles in maintaining high standards. Regular feedback and engagement sessions will be held to foster a culture of accountability and continuous improvement. This will be facilitated through monthly staff meetings, and additionally on a one-to-one basis.

To further support effective governance and supervision within the Centre, the Director of Nursing and Assistant Director of Nursing are on site in the Centre, Monday to Friday, and a supernumerary CNM is also on site in the Centre during weekends.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Immediately following the inspection, the Director of Nursing conducted a full review of all complaints on file to identify cases that had exceeded the 30-day resolution period. Results demonstrated delays in closing complaint cases was due to the lack of response from complainants regarding their satisfaction with the outcome.

The following steps were taken to address this delay in the complaints process:

The Center's Complaints Policy was revised and updated to ensure clear guidelines for

timely complaint closure and communication.

The Director of Nursing will ensure all complaints are investigated and a response is provided to the complainant within 30 days. The outcome will be clearly communicated to the complainant.

The complainants with be provided with a 10-day window to respond, indicating whether they are satisfied with the resolution or if they wish to appeal.

If no response is received within the 10-day window, the Director of Nursing will proceed to close the complaint and inform the complainant that the case has been closed.

The Director of Nursing and Assistant Director of Nursing will monitor the implementation of the revised policy and ensure compliance with the new procedures. Both open and closed complaints will be regularly reviewed in the weekly Director of Nursing and Regional Manager Clinical Meeting to ensure all steps have been followed.

Monthly reviews will be conducted of the complaint management process to assess effectiveness and identify any further improvements needed.

To further enhance our interaction with residents and relatives, an independent advocate has been appointed and commenced in this position August 06th, 2024.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The Complaints Policy, Medication Management Policy and Fire Safety Policy has been recommunicated to all relevant staff members to ensure understanding and awareness.

Toolbox Talks training sessions have been conducted for all staff on the proper implementation of these policies, with practical scenarios included to reinforce understanding.

Through direct supervision/observation by the local management team, any identified gaps in the implementation of these policies will be addressed. The Director of Nursing will ensure that any issues are resolved promptly and that all staff are following procedures as required.

In addition, regular audits will be implemented to monitor compliance with these policies. Findings will be documented, and feedback provided to staff highlighting any areas for improvement.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A phased refurbishment plan developed prior to the Inspection was enhanced to incorporate the recommendations of the Inspectors. To date, 7 rooms has been upgraded and completed to the higher standard. Progress updates have been shared with the Regulator and the Provider will continue this as each area is completed. Bedrooms will not be occupied until the completion of this upgrade work. Phase 1 consisting of 10 rooms in Estuary C will be completed by August 16th, 2024.

The bedside lockers and wardrobes in unoccupied bedrooms in the Castle unit that were found to be in disrepair will be promptly repaired or replaced as needed to ensure they are fit for purpose.

Privacy screening in twin rooms will be installed or upgraded where the current arrangements do not sufficiently ensure resident privacy. Priority will be given to rooms lacking screening around beds near bedroom doors. Until this work is completed, only one resident will be admitted to shared rooms.

Repair and replacement of damaged flooring commenced July 29th. To date 4-bedroom floors and 6 bathroom floors have been replaced.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Emergency lighting will be installed outside all emergency exit doors where it is currently lacking. This will be completed by October 31st, 2024.

A full repair / replacement programme for all fire doors has commenced which will include replacement of all non-fire-rated hinges and ironmongery on fire doors throughout the Centre. All Fire Door repairs in Estuary B have been completed August 09th, 2024; with report pending. Expected completion date for all other units is December 31st, 2024.

A structured schedule for regular fire drills has been implemented, including simulated fire drills to test staff capability in real-life scenarios. This includes drills for evacuating the largest compartment with nighttime staffing levels, completed on August 09th, 2024.

The importance of daily and weekly fire safety checks has been emphasized to both the

Nursing and Maintenance Teams. Roles and responsibilities have been clearly defined to ensure that both the RGN and Maintenance teams are fully trained and understand their duties. Daily fire safety checks will be carried out by the Nursing Team, with each individual RGN responsible for their respective unit. The Maintenance Department will oversee the process by conducting weekly checks, which will be audited monthly by the Support Services Manager to ensure continued compliance with this process.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
All prescribed medications, including oral nutritional supplements, laxatives, and eye drops, will no longer be left in unattended areas and securely stored in the designated medication storage areas within the Centre.

A meeting with the Pharmacy has reiterated this revised process and all medications will require on delivery a signature from an RGN.

Daily checks of all units has been implemented, including Estuary B, to ensure that all medications are stored correctly. Any deviations from the policy will be addressed immediately.

The medication management policy, to include storage of medications has been reviewed to ensure it reflects best practices and includes clear guidelines on preventing improper storage of medications.

Monthly reviews of the medication storage procedures will be conducted by the CNM's across all units to ensure long-term compliance and address any emerging issues promptly.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
• All resident weight recordings have been reviewed and completed by the Assistant Director of Nursing. Daily oversight of the Centre's Clinical Management System will be implemented by the CNM's to monitor weight recordings and ensure they are conducted

at the appropriate frequency. The Nutrition Policy has been updated to specify that all monthly weight measurements must be completed by the 5th of each month to ensure consistency. Any resident refusal to have their weight recorded will be clearly documented. All staff have been reminded of the importance of adhering to these guidelines.

• The Director of Nursing and Assistant Director of Nursing conducted a full review of all residents with wounds to ensure that wound care plans are properly developed and implemented for each case. Monthly audits will be completed to ensure that wound care plans are consistently in place and up-to-date.

• The care plan for the resident at risk of absconsion, which only mentioned "close monitoring," has been revised to include specific strategies and actions required to mitigate this risk. The local Management Team have conducted a thorough review of all absconsion care plans to ensure they provide clear, actionable guidance.

• The issue of duplicated care plans, which resulted in conflicting information, has been noted. The Assistant Director of Nursing is in the process of streamlining documentation processes to eliminate unnecessary duplication. This will ensure that all care plans provide the most current and accurate information regarding each resident's assessed needs.

• A full review of all Resident’s Daily Personal Care Records is currently being conducted by the Centre’s CNM’s.

In addition, all resident care plans are currently being reviewed and updated to ensure they accurately reflect each resident's assessed needs. This will be completed by August 30th.

Ongoing training and support are being provided to all nurses to emphasize the importance of continuous assessment and care planning. This training is scheduled for completion by August 31st, 2024. Additionally, three staff members have been designated as Care Plan Champions for the Centre. The final phase of their training will be completed by August 28th. These Champions will play a key role in enhancing the care planning process within the home, with a responsibility to monitor care planning on a daily basis.

Increased audits of assessments and care plans has also been implemented within the Centre to ensure full compliance. These audits include reviews of relevant assessments and care plans to verify that care is being delivered in accordance with residents' documented needs. The Clinical Nurse Managers in each unit are responsible for conducting these audits, with additional oversight from the Assistant Director of Nursing and the Director of Nursing.

Any findings or necessary quality improvements will be communicated regularly to all staff during formal staff meetings and daily handovers to ensure consistent and clear communication on the importance of accurate care planning and assessment.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
The existing policy on restrictive practices has been reinforced through daily handover with all staff, highlighting the necessity of trialling, testing, and documenting alternatives before implementing any form of restraint.

Toolbox talks on Restrictive Practices have been conducted by the Director of Nursing and are ongoing. This initiative will be further supported by onsite training scheduled for August 30th for RGNs, focusing on the proper understanding and implementation of restrictive practices. The training will cover:
• The importance of exhausting all alternatives before resorting to restraint.
• The correct documentation of the trial and failure of alternatives in care plans.

In addition, the local Management Team has completed a comprehensive review of all current care plans to ensure that any use of restraint is fully justified, with documented evidence that alternatives have been trialed. Care plans have been updated as necessary to reflect this process.

The Centre have also increased the frequency of audits on restraint use to ensure strict adherence to policy. These audits will focus on:
• Proper consideration and documentation of alternatives.
• Ensuring restraint is used only as a last resort.
• Verifying that staff are accurately following procedures.

Ongoing support and guidance will continue to be provided to staff through regular check-ins and team meetings, reinforcing the critical importance of prioritizing alternatives to restraint. Any concerns or gaps in knowledge that arise will be addressed promptly.

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(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	31/12/2024
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.	Not Compliant	Orange	31/12/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure	Substantially Compliant	Yellow	31/08/2024

	that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	31/12/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/10/2024
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	31/12/2024
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Not Compliant	Orange	31/07/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/12/2024
Regulation 29(4)	The person in	Substantially	Yellow	15/07/2024

	charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Compliant		
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Substantially Compliant	Yellow	31/08/2024
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	19/07/2024
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	31/08/2024
Regulation 5(3)	The person in	Substantially	Yellow	31/08/2024

	charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Compliant		
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	10/08/2024