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:	11 January 2023
Centre ID:	OSV-0000182
Fieldwork ID:	MON-0038488

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 modern 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:	90

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 11 January 2023	08:50hrs to 17:55hrs	Helena Budzicz	Lead
Wednesday 11 January 2023	08:50hrs to 17:55hrs	Helen Lindsey	Support

What residents told us and what inspectors observed

During the inspection, inspectors met with many of the 90 residents who were living in the centre and spoke with ten residents in more detail. The overall feedback from residents and relatives was that Talbot Lodge nursing home was generally a nice place to live and that the staff were kind to residents. However, they also said that there had been a number of issues recently with staff shortages and staff turnover. Inspectors also observed that action was required to ensure residents' safety and the experience was promoted at all times. This will be discussed under the relevant regulations. On arrival at the centre, the inspectors saw that the reception area was bright and welcoming; however, there was no staff available to guide inspectors through the infection prevention and control procedures.

The inspectors waited for a period of time of 15 minutes before the clinical nurse manager (CNM) arrived and informed them that they were the only management personnel on duty and also working as a staff nurse that day due to staff being on leave. The CNM informed the inspectors that there had not been a person in charge or Assistant Director of Nursing (ADON) assigned to the centre for a number of weeks. Following an introductory meeting with the clinical nurse manager and afterwards with the Group Clinical Director, who arrived later, the inspectors completed a tour of the premises, which also gave them the opportunity to meet with residents and staff as they prepared for the day.

During the morning walkaround, inspectors saw that many residents were staying in their bedrooms, with only a few residents sitting in the communal areas. Staff informed inspectors that they would bring residents to the dining rooms shortly before lunch. The staff member informed inspectors that this is a daily practice in the centre and that there is no staff available to provide activities as they are occupied providing care. Many residents who the inspectors met were unable to fully verbalise their needs and wishes due to their cognitive or communication impairments. Inspectors observed that these residents appeared well-dressed and groomed and were seated comfortably. However, there was little interaction between staff and residents, and one-to-one activities, such as nail care activities, were taking place in one unit only.

The inspectors observed the lunch time meal experience in different areas of the centre. Not all units were appropriately supervised, and there were long waiting times in between the courses where residents waited for the food to be served. Food served to residents appeared appetising and nutritious. The dining room tables were nicely decorated with table clothes, and condiments were available for residents' use. However, inspectors observed that not all tables in the Castle unit were covered with table cloths. The top of some of the tables was very unclean, and there were stained markings from paint.

As the two activity coordinators had recently resigned, the schedule of activities was limited in the centre on the day and weeks before the inspection. On the day of the

inspection, there was a newly recruited activity coordinator; however, inspectors saw that the activities were taking place in one of the four units only during the day, and not all residents were provided with opportunities to participate in activities in accordance with their interests and capacities. Inspectors observed many residents sitting in the day rooms watching television for long periods of time without additional interaction or engagement. In general, inspectors saw that staff were kind to residents during the inspection; however, due to the shortage of staffing and in the absence of management oversight, staff concentrated on residents' personal care and only sometimes had time to support residents with activities.

The next two sections of the report will present findings in relation to governance and management in the centre and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced risk inspection during which the compliance plan from the previous risk inspection carried out in January 2022 was followed up, together with a number of issues of concern received on five different occasions from members of the public since the last inspection.

The provider had not taken sufficient action to ensure the designated centre was meeting the needs of residents and operated in line with the requirements of the regulations and standards. Governance systems were not in place to effectively oversee the running of the centre. For example, there was no management team employed in the centre at the time of the inspection with only one Clinical Nurse Manager in place, and there were high levels of vacancies in nursing and healthcare assistant (HCA) posts also. Due to the reduced staffing and management levels, supervision of staff was not in place, and inspectors observed some staff practices that were not in line with local policies. For example, some staff were observed not wearing personal protective equipment (PPE) when required; and there was a lack of support and assistance for residents at mealtimes. While the atmosphere in the centre was relaxed on the day of inspection, the reduced staffing levels were significantly impacting on residents' opportunities to be up and ready for the day before lunch and engage in meaningful activities for a good quality of life.

The registered provider was Knegare Nursing Home Holdings Ltd. There was a Chief Executive Officer (CEO) who reported to the Board and a Group Clinical Director engaged in the governance of the centre. The provider operates three other designated centres with the same group-level personnel. Inspectors were informed that the person in charge post was vacant at the time of the inspection, and the staffing records showed that no one had worked in the centre in that post since the middle of December. The Assistant Director of Nursing (ADON) post was also vacant, and staffing records showed this post vacant for November and December 2022. There was one clinical nurse manager (CNM) on the staff records. This CNM

was on duty on the day of inspection but working as a staff nurse with direct resident care responsibilities rather than in a supernumerary management capacity. The clinical director informed the inspectors that they were responsible for the oversight of the centre at the time of the inspection, and they liaised with the inspectors as required.

The governance systems in the designated centre were seen to be insufficient and ineffective. Management meeting records were not detailed, and the items on the agenda did not include aspects related to direct care delivery or the quality of the service being provided. The folder of management meetings provided had records called 'weekly governance meetings', but copies present in the folder showed that these meetings did not take place every week. The meeting notes were brief and handwritten and provided little detail of the issues discussed, the proposed plans on how to respond or nominated people responsible for agreed actions. While there were photographs of members of specific committees in the training room, such as an infection control committee, records of meetings were not available, and their role in the management systems of the centre was unclear.

Management meetings recorded that a small number of audits were being completed by the management team. Copies were seen of audits on hand hygiene, infection prevention and control, cleaning and a monthly health and safety alert. While templates included an action plan, this was not consistently completed. The audits did not record if actions had been completed. Inspectors observed examples of issues identified in the infection prevention control audit from October 2022 that had not been addressed at the time of the inspection, for example, poor storage practices and the poor processes around the cleaning of equipment. Inspectors also identified that some areas signed off as in place on the audits were not reflected in inspectors' observations, for example, the lack of appropriate facilities in the sluice rooms or the damaged sinks that could not be effectively cleaned.

The staffing rostering system did not provide a clear overview of who was working on each shift and whether the expected level of staffing was met. Inspectors were shown supplementary documentation used to record staffing levels in each unit each day. Nevertheless, the inspectors were not clear from the documents provided what the actual staffing levels were on the day of inspection. Staff on duty informed inspectors that there was a nurse shift and other healthcare assistants (HCA) shifts not covered. In addition, the CNM was not available for the day-to-day oversight of the centre as she was working to cover the nurse shift. This significantly depleted staffing level and skill-mix had a negative impact on care with poor outcomes for residents, as evidenced and further outlined in the findings under Regulation 16: Training and staff development and Regulation 8: Protection.

While documentation in relation to the staff leavers and new joiners was provided on request, the management structure and the key roles overseeing the care were not clear on the day of inspection. The provider representative stated there were six nursing staff vacancies and 11 HCAs across the organisation. However, inspectors also noted there was only one clinical nurse manager identified when the centre's statement of purpose (SOP) stated there would be four. Also, there was only one activities coordinator when the SOP stated there would be two. The provider

representative confirmed recruitment for nursing and HCA staff was ongoing, and a document was seen with start dates for some new staff.

There was inadequate supervision and oversight of the staff team. Staff reported that some members of the management team had resigned a while ago, and the agency staff was working mainly during the night. As a result, the supervision of staff and staff practices were limited and required action, as evidenced under relevant regulations in this report.

Records showed that there was a planned approach to inducting new staff, which covered staff facilities, policies, and an introduction to the centre.

A complaints register was held in the centre. Inspectors reviewed a sample of complaints from 2022 and 2023 and found that overall when complaints were received, they were responded to within the timescale set out in the policy. Records showed the issues raised through complaints were followed up on. For example, there were records of maintenance being done to address issues such as heating not working in bedrooms and faulty emergency call cables. Records showed feedback had been provided to the complainant, or meetings had been held to discuss the issues raised. The record identified closed complaints with the satisfaction level of the complainant documented. There was a policy displayed in the designated centre, and it was updated on the day of inspection to reflect the correct person who would manage any complaints made. Residents confirmed they knew who to speak with if they wanted to raise a concern.

Regulation 14: Persons in charge

There was no person in charge at the time of the inspection, and the registered provided had not formally notified the Chief Inspector of this absence or vacancy.

Judgment: Not compliant

Regulation 15: Staffing

There were insufficient staffing levels with the required skill-set to ensure the needs of residents were met. This directly impacted on the quality of residents' care in that:

- Some residents were not supported to get out of bed and dressed up until midday.
- Residents' meal times were delayed, and the dining rooms were unsupervised at times due to insufficient staff being available.
- Communal rooms in three of the four units observed were not supervised.
- One staff member was responsible for activities across all four units, which

resulted in very limited activities being available for residents on the day of the inspection. There were limited activities in the morning in all units other than Mass and nail care.

On the day of the inspection, there was no management team employed in the centre. The person in charge and Assistant Director of Nursing (ADON) posts were vacant, and there was only one clinical nurse manager (CNM) out of four posts described in the staffing complement in the statement of purpose (SOP). The group clinical director, a representative of the provider, was overseeing the day-to-day management of the centre.

The representative for the provider informed inspectors that there were six staff nurse vacancies and eleven healthcare assistant (HCA) posts vacant, which resulted in excessive use of agency staff to cover shifts. This resulted in a lack of continuity in residents' care.

Judgment: Not compliant

Regulation 16: Training and staff development

There was a document in place that summarised the training each member of staff had received. The majority of staff had completed safeguarding and fire safety training, with additional training sessions booked. However, inspectors found that staff members across all disciplines did not have an appropriate level of knowledge to ensure that residents were appropriately safeguarded and afforded a good and safe level of care. Some areas where inspectors found gaps in staff members' knowledge included infection prevention and control, fire safety and evacuation practices, care planning, and safeguarding of residents' and residents' rights.

Staff were not effectively supervised as a result of depleted management structures. This was particularly important due to the high levels of agency used. On the day of the inspection, the clinical nurse manager advised she was rostered in a supernumerary capacity but was working as a nurse delivering care to residents as there was an uncovered shift that day.

Judgment: Substantially compliant

Regulation 21: Records

Inspectors reviewed staff files and found that not all staff had their references on file as required in Schedules 2 and 4 of the regulations. Inspectors saw that six references were missing. The provider submitted two references following the inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider did not have sufficient resources available to ensure the service was effective and delivered in line with the statement of purpose.

- The management structure was not appropriate to ensure effective oversight of the designated centre and did not align with the statement of purpose. A clinical nurse manager was working in a nursing capacity, and the group clinical director was overseeing the operation of the centre on the day.
- There was no evidence that any arrangements had been made to replace key management personnel involved in the running of the centre
- The staffing complement available on the day of the inspection was not sufficient to ensure residents' needs could be safely met.
- Premises were worn and damaged in places with no records or plans to address this. One unit had been refurbished, but the sluice room and bathroom had equipment that was damaged and required replacing- no plans were seen to provide assurance it would be addressed.

There was limited information available to provide assurance that the registered provider had management systems and an organised approach to ensure residents were provided with a service that was safe, appropriate, consistent and effectively monitored. Inspectors saw the following evidence that the oversight arrangements were not effective:

- There were a number of risks identified on the day of inspection which had not been identified by the provider or their auditing system. An immediate action plan was issued to the provider on the day of inspection in respect of fire safety, as the keys were missing besides the fire doors. The group operation manager informed inspectors that this action plan was completed and all keys were in place.
- Care plans for residents were of a poor standard, and gaps were identified where residents had healthcare needs but no care plan to guide staff on how to respond to these needs.
- Five incidents had occurred in the centre that had not been responded to appropriately by following the centre's safeguarding policy.
- The quality of the audit systems was poor; the audits reviewed only covered limited topics and did not include a follow-up on identified actions. For example, the audit findings of an infection prevention and control audit carried out in October 2022 had not been addressed at the time of the inspection.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

A contract of care was in place for residents. It set out the services provided in the designated centre, the fees to be charged, the fair deal arrangements, and also any additional fees to be paid.

Of the 15 contracts reviewed by inspectors, five did not include the number of the room to be occupied, the occupancy of the room, or both.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Inspectors identified five different incidents that had occurred in the centre that had not been dealt with appropriately. They had not been appropriately recognised as safeguarding concerns, and the incidents were not notified to the Chief Inspector within three days, as required by the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a procedure in place that set out the process to be followed when a written or verbal complaint was received.

There was a record of complaints that had been made in the centre, and documentation showed that issues had been reviewed and discussions held with the complainant.

Issues raised included concerns about the level of care being provided, premises issues, staffing turnover, and staffing levels. A number of complaints had been raised by residents, and those who spoke with inspectors during the inspection confirmed they knew who to speak to if they had any concerns.

There was a copy of the complaints policy displayed in the centre. The copy in reception was updated on the day of inspection to identify the correct person nominated to deal with complaints in the centre.

Judgment: Compliant

Regulation 4: Written policies and procedures

The policies and procedures required under Schedule 5 of the regulations were in place, and inspectors were informed that they were currently under review. However, inspectors found that a number of policies were found not to be implemented in practice; for example, safeguarding policies refer to different nursing home names. This is further discussed under respective regulations.

Judgment: Substantially compliant

Quality and safety

Overall, there was mixed feedback from residents in relation to the quality of life in the centre. While residents stated that staff were kind, caring and responsive to their needs, some residents said that there were limited activities available and they were bored. The quality of care and safety provided to the residents was not found to be monitored and reviewed regularly in the centre. The changing needs of the residents were not addressed and recorded appropriately, and there were inadequate arrangements in place to ensure residents' health and social care needs were met, which ultimately posed risks to the residents' safety and quality of life. The action was also required in the areas of fire safety, protection, residents' rights, infection control, premises and care planning.

Residents had good access to medical care and were reviewed regularly by their general practitioner (GP). Residents were also provided with access to other healthcare professionals in line with their assessed needs. However, inspectors were not assured of the overall standard of nursing care being provided or that validated tools were used in carrying out nursing assessments. Furthermore, care plans were not initiated within 48 hours from admission, and some care plans were not regularly reviewed and did not provide adequate detail on the care to be delivered based on advice from health and social care professionals involved in residents' care. This is discussed in more detail under Regulation 5: Individual assessment and care plan of this report.

Infection prevention and control training had been undertaken by staff; however, inspectors observed that not all staff practices were in line with the centre's policy, and the oversight of storage practices and cleanliness of the centre did not ensure that the risk of cross-contamination was appropriately mitigated as detailed under Regulation 27: Infection Control.

Inspectors observed that some parts of the centre were already renovated. Notwithstanding the improvements made, inspectors found that maintenance of the premises did not ensure all areas were in a good state of repair and were adequately maintained for the comfort and safety of the residents. Inspectors found

unidentified risks and issues of concern relating to premises and fire safety. Overall, on this inspection, fire safety management and the systems of risk management to identify fire safety risks were not effective in ensuring the safety of residents living in the centre.

The provider acted as a pension agent for four residents. The processes in place were in line with the Department of Social protection guidance.

Although the centre had a safeguarding policy in place, inspectors were not assured that the provider put all measures in place to ensure residents were protected and safeguarded from repetitive occurrences of incidents involving an allegation of abuse. The systems in place and staff knowledge were found not to be effective and adequate, and the monitoring process in the centre did not ensure that there was no further risk of institutional abuse due to a lack of oversight and supervision.

Inspectors found that residents were not provided with opportunities to consult with management and staff on how the centre was run. Additionally, some improvements were required to ensure that residents may undertake personal activities in private and that their rights to privacy and dignity were supported at all times. Inspectors were also not assured that there was adequate access for residents with increased dependency needs to scheduled group activities and one-to-one activities.

Regulation 17: Premises

The registered provider did not ensure, having regard to the needs of the residents, that the premises conformed with matters set out in Schedule 6. The following issues identified in relation to the maintenance of the premises required action to be compliant with the requirements of the regulations:

- Areas in the centre were found to not be kept in a good state of repair. For example, there were holes in the plaster in the ceilings in the corridor in the Castle unit and in the communications room/ Store. There was a large hole in the wall in the domestic room in the Castle unit.
- There were exposed sockets in the store room, and the fuse board was not locked in the dining/sitting room in the Castle unit, which posed health and safety hazards for residents.
- There were damaged and chipped doors, door frames and skirting boards along the corridors. Some floor covering was also damaged.
- The paint in some bedrooms was damaged and peeling off, and some radiators were also in need of being painted.
- Inspectors observed signs of leakage on a number of the ceilings across the centre.
- Emergency call facilities were missing in the communal bathrooms, shower corners, oratory and two sitting rooms.
- Not all residents had access to lockable storage spaces and secure facilities for the safe-keeping of their personal possessions and valuables.

- The equipment to be used by residents was not in good working order. For example, inspectors observed a cracked toilet seat that posed a safety risk to the residents. A number of pieces of broken equipment were seen stored in the sluice rooms. In addition, a dishwasher was observed to be faulty, and leaking and towels were used on the floor to prevent trips and falls. Inspectors spoke with the staff, who confirmed that the leaking dishwasher was reported for service.

Judgment: Not compliant

Regulation 27: Infection control

The registered provider did not ensure that procedures consistent with the National Standards for Infection Prevention and Control in Community Services (2018) published by HIQA were implemented by staff. This was evidenced by the following:

- Inspectors observed inappropriate storage practices in the centre. For example, in the sluice rooms, there were shower chairs, linen bags and trolleys, residents' wheelchairs and specialised chairs, nail manicure trolleys with equipment and cleaning equipment such as mops and dust brushes.
- Boxes were seen to be stored on the floor, preventing the floor from being appropriately cleaned
- Some equipment, such as dining trolleys, bain-marie, and shower chairs, were seen to be dirty, greasy and rusty.
- The sinks, sluice hopers, bedpan washers and worktops were visibly dirty and unclean in all sluice rooms in the centre.
- There was dirt and mould observed in the treatment/ medication room around the sink and backsplash.
- Several cobwebs were observed along the corridors, and there was no evidence that high dusting was being carried out regularly.
- Staff were observed not adhering to the PPE policy as they were not wearing masks in the centre; where masks were used, they were worn incorrectly underneath the nose.

Judgment: Not compliant

Regulation 28: Fire precautions

Inspectors were not assured that the emergency escape lighting provided throughout the centre was adequate. For example:

- Escape signage was not visible in all corridor and room areas, and so would

not direct residents and staff in the case of an emergency.

The many deficits observed in respect of premises and the lack of proactive maintenance and repair did not assure the inspectors that the arrangements for the containment of fire in the centre were adequate. For example:

- There was a large hole in the wall in the domestic room in the Castle unit.
- Part of the plastering on the wall in the communications room was missing on the part of the wall. The doors in this room were not closing, and it was used as a storage room; this was a high-risk area.
- A number of fire doors were observed to be wedged open across the centre
- The self-closing mechanism holding the door was broken on one fire door and some of the fire doors were badly damaged.
- Inspectors observed gaps in some cross-corridor fire doors, and some were not closing correctly; this posed a risk that in the event of a fire, the smoke would not be effectively contained.
- Inspectors observed Break Glass key holder boxes beside the fire exit without the Printed Glass or the key. Inspectors issued an immediate action plan in this respect which was addressed on the day of the inspection.
- There were broken window handles in the sitting and dining rooms, and therefore, some windows couldn't be closed, which posed the risk of fire and smoke spreading.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

While there were some assessments completed for residents and some care plans in place, not all healthcare needs were identified and addressed in the care plans and not all care plans were completed in a timely way:

- While there was evidence of the tissue viability nurse review for pressure ulcers in the centre and residents' wound assessments were available, some wound care plans were not updated in line with the tissue viability nurse instructions; this posed a risk to the residents as the care plans would not guide staff to provide the required care as per residents' assessed needs.
- Residents with urinary catheters had no care plan to guide the staff and support residents' well-being.
- Residents with insulin-dependent conditions did not have their care plans updated despite changes in their treatment.
- Newly admitted residents did not have their assessment and care plans prepared within 48-hours after their admission as per regulatory requirements. Some of the assessments and care plans were initiated 10 days post-residents' admission to the centre.

Judgment: Not compliant

Regulation 6: Health care

Records showed residents had access to a general practitioner (GP) who visited the centre on a regular basis. There was evidence of residents being reviewed by dietician, SALT, GP and physiotherapist. Residents were also linked with relevant specialists in relation to their health conditions, for example the geriatrician service, and psychiatry of old age.

Judgment: Compliant

Regulation 8: Protection

The inspectors were not satisfied that the provider had taken all reasonable measures to protect residents from abuse, as evidenced by the following:

- The centre's policy on safeguarding vulnerable adults states that the person in charge should complete the preliminary investigation of the incident, and the provider will establish the investigation team of staff members within a home. This is not in line with the regulatory requirement that the person in charge should investigate the incident. The policy also referred to other nursing home policies and procedures.
- Inspectors found eight alleged incidents of some form of abuse, either physical or verbal, where two residents were involved. These incidents were not investigated and followed up on as per the centre's policy. There were no safeguarding care plans available to protect residents from further incidents of abuse.
- While safeguarding training was scheduled and completed by staff members, the staff and management of the centre failed to recognise forms of abuse and take appropriate actions to safeguard residents in the centre.

Judgment: Not compliant

Regulation 9: Residents' rights

Action was required to ensure that all residents were provided with opportunities to participate in activities in accordance with their interests and capacities;

- A large number of residents spent a considerable amount of time in their bedrooms with minimal stimulation other than television and radio.
- Residents were left in the sitting rooms without supervision, with a television or radio on or no active stimulation at all.
- Inspectors observed a lack of activities across the centre. Nail care was observed to be provided only in one unit in the morning, and in the afternoon, bingo took place in one unit only, where only some residents were able to attend.
- From speaking with the residents and from the records, it was evident that residents had limited opportunity to discuss the quality of life and other activity opportunities in the centre. A residents' committee was in place, which should have met every two months to discuss any concerns or suggestions for residents. However, the records showed that the last residents' meeting occurred in September 2022. Inspectors saw that no further follow-up was recorded on the actions required based on the feedback received from residents.

Action was required to support residents to exercise choice, uphold their dignity and undertake personal activities in private;

- The doors to the garden areas and courtyards were locked across the centre, restricting residents' access to outdoor space.
- Call-bells were hanging from the ceilings above residents' beds and were not within residents' reach; this meant that residents could not call for assistance if and when required.
- Residents' dignity was not always upheld as inspectors observed a resident being transferred to a communal bathroom across a corridor covered up with towels and without lower body clothing. Furthermore, the staff did not lock the bathroom door while supporting this resident with a shower.

Judgment: Not 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 14: Persons in charge	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Talbot Lodge Nursing Home OSV-0000182

Inspection ID: MON-0038488

Date of inspection: 11/01/2023

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: Regulation 14 (1) There shall be a person in charge of a designated centre. A new PiC has been appointed and has confirmed she will commence on 02-05-23. 7-day management cover is to be achieved through the below appointments: • Presently, our CNM2 works Monday to Friday in the centre in a supernumerary capacity from 8am-4pm. Our CNM2 has enrolled on Leadership and Management course in late March 2023 to equip her with the skills required to be effective in her role. The CEO is on site 3/4 days per week and the Operations Director is on site 3 days per week. The Clinical director continues to support the Nursing Home Team by telephone and strives to be on site one day per week. A Group Compliance and Quality Manager is commencing on 03-04-23 and will be on site at least 1 day per week once inducted until the new PiC joins. ***The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the Regulation 14: Person in Charge***.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Regulation 15(1) The registered provider shall ensure that the number and skill mix of	

staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned

The centre currently has 6x registered nurse vacancies but forward planning from 2022 means that these vacancies will all be filled in the coming months (we have over hired to allow for challenges with AWS visas and to allow for potential dropouts):
• 4 x nurses commencing induction on the week commencing 20-03-23. These nurses have all passed their RCSI Aptitude Test and 1x is awaiting her MNBI pin that is expected in the coming days
• 14 x Nurses were due to arrive in April 2023 to complete aptitude testing on 16th and 22nd of April - 7 applicants have been successful in receiving AWS visas. However, AWS visas for 7 other applicants have been declined and their Aptitude Tests have been rescheduled for July 2023, with the intention of bringing the test date forward if they are successful with their AWS applications.
• This will leave us with a surplus of nurses if the 7 nurses who had their AWS visas declined are successful with their AWS applications.

The centre currently has 3x HCA vacancies but 8x HCAs with offers accepted and awaiting Garda Vetting. The centre expects not to require agency HCAs from 27-03-23. 6x HCAs commenced post inspection.

The centre has 1x vacancy for a part time / relief Housekeeping Staff. Two candidates have commenced and completed inductions post the inspection.

The centre currently has no kitchen assistant vacancies and 2x kitchen assistants commenced post inspection.

Staffing within the centre is reviewed using a validated staffing tool, taking into consideration the dependencies, size and the lay out of the Nursing Home.

Staffing within the centre is expected to be at full compliance as per the Statement of Purpose by end of April 2023.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Regulation 16(1)(a) The person in charge shall ensure that staff have access to appropriate training.

The training Matrix is under review to ensure all staff have appropriate training in place. Staff competency on all aspects of training is reviewed through observation of care practices, audit and routine drills (Fire, Missing Person etc).

The Operations Director is on site at least 3 times weekly to supervise and support on non-clinical issues.

A Compliance and Quality Manager is due to commence for the group on 03-04-23 which will add another layer of governance and support on clinical issues to the management of the centre.

Presently, and in the absence of the ADoN and DoN, the CNM2 provides support and oversight to the centre.

Regulation 16(1)(b) The person in charge shall ensure that staff are appropriately supervised.

There are 6 Team leaders within the centre who supervise and support the Healthcare Assistants on a daily basis.

Staff Nurses are supervised and supported by the CNM2. The CNM2 is supported by two CNM1s in the centre who will be providing supernumerary support from the week commencing 20-03-23.

There is a housekeeping supervisor and Head Chef who support and supervise their team members when on duty.

Currently the Operations Director and CEO are supervising the non-clinical auxiliary teams. We have been unsuccessful to date in securing short term clinical oversight. We continue to work on this and have made an offer to the previous PiC to return for at least 3 days a week until the new PiC joins.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records: Regulation 21(1) The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

A full review is underway of all staff files by the Senior Administration Team to ensure they contain all the information as laid out in Schedule 2 noted above. The Operations Director has devised and implemented an audit system on 24-02-23 which will capture all new staff, once an offer of employment is made and track them and their compliance paperwork prior to and post commencement of employment.

Staff File Audits will continue monthly onsite by the Senior Administrator and will be inspected and reviewed by the Operations Director.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Regulation 23 (a) The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

Currently we are awaiting a number of both Nurses and Health Care Assistants to commence in the centre.

The centre currently has 6x registered nurse vacancies but forward planning from 2022 means that these vacancies will all be filled in the coming months (we have over hired to allow for challenges with AWS visas and to allow for potential dropouts):
• 4 x nurses commencing induction on the week commencing 20-03-23. These nurses have all passed their RCSI Aptitude Test and 1x is awaiting her MNBI pin that is expected in the coming days
• 14 x Nurses were due to arrive in April 2023 to complete aptitude testing on 16th and 22nd of April - 7 applicants have been successful in receiving AWS visas. However, AWS visas for 7 other applicants have been declined and their Aptitude Tests have been rescheduled for July 2023, with the intention of bringing the test date forward if they are successful with their AWS applications.
• This will leave us with a surplus of nurses if the 7 nurses who had their AWS visas declined are successful with their AWS applications.

The centre currently has 3x HCA vacancies but 8x HCAs with offers accepted and awaiting Garda Vetting The centre expects not to require agency HCAs from 27-03-23. 6x HCAs commenced post inspection.

The centre has 1x vacancy for a part time / relief Housekeeping Staff. Two candidates have commenced and completed inductions post the inspection.

A Group HR Manager has been appointed and will commence on 27-03-23. This will add another layer of oversight in relation to documentation and staff files.

Currently the Board of Management are reviewing the internal control practice and procedures, including auditing, risk management and health and safety and IPC oversight to ensure that the services provided are safe, appropriate and consistent across the group.

Regulation 23 (b) The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies

roles, and details responsibilities for all areas of care provision.

In the absence of a DoN the Board of Management, including the CEO and Operations Director feature heavily in the day to day running of the Nursing Home.

A Group Compliance and Quality Manager is commencing on 03-04-23 and will be on site at least 1 day per week once inducted until the new PiC joins

7-day management cover is to be achieved through the below appointments:

• Presently, our CNM2 works Monday to Friday in the centre in a supernumerary capacity from 8am-4pm. Our CNM2 has enrolled on Leadership and Management courses in March 2023 to equip her with the skills required to be effective in her role.

• A CNM1 is due to commence providing supernumerary support Monday – Friday from 12pm – 8pm on at least 3 days per week and also to provide weekend supernumerary cover from 8am – 8pm from the week commencing 20-03-23

• An additional CNM1 is due to commence providing weekend supernumerary support from 8am-8pm Saturday & Sunday from the week commencing 03-04-23 when she returns from annual leave. This CNM1 will also provide supernumerary support Monday – Friday from 9am-1pm on at least 2 days per week

Regulation 23(c)The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Currently the Board of Management are reviewing the internal control practice and procedures, including auditing, risk management and health and safety and IPC oversight to ensure that the services provided are safe, appropriate and consistent across the group.

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
Regulation 24(1)The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.

A comprehensive review of the Contracts of Care is underway to ensure that all the information pertaining to the resident and noted during the inspection is included in the

contract. Where deficits are noted these will be amended to ensure full compliance. All new contracts will be reviewed by the Senior Administrator prior to them being released to ensure all the required information is captured.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Regulation 31(3) The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

A full review of the incidents and accidents in the centre has taken place and all notifications that were required have been submitted retrospectively.

In the absence of a PiC the incidents are reviewed daily by the CNM2 on site and discussed with the Clinical Director to ensure that all notifications required are submitted in a timely fashion.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Regulation 4 (1) The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

Policies within the centre were under review at the time of inspection and an independent external professional agency has been assisting with the Schedule 5 policies.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

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

Fuseboard in the dining/sitting room in Castle has been fitted with a lockable door. A cover has been ordered and is to be fitted by an external contractor for the exposed sockets in the storeroom in the Estuary B unit, the door of this storeroom has also now been locked.

Holes noted in the communication room and domestic cupboard were attended to on 17-02-2023, external contractor is due back on site on the week commencing 20-03-23 to finish off and to address other issues noted following full building audit completed by the Group Operations Director and Group Facilities Manager on 16-03-23

Staining from leaks will be painted by 30-03-23

Broken equipment has been removed from storage and sluice areas and dumped, completed on 20-02-23.

New parts were ordered for the dishwasher and delivered on 15-02-23. However, the dishwasher continues to cause problems. We are currently in the process of sourcing an alternative service contractor as we don't feel the current company are servicing adequately. In contact with other potential suppliers. The risk of slips has been identified and added to the risk register

Castle communal areas and bedrooms were painted in November 2022 and 6 bedroom floors replaced. Estuary B Area (all 20 bedrooms and communal areas) were totally refurbished and upgraded in 2021-2022. A schedule of works is in place to ensure the remaining 2 areas (Seabury and Estuary C) are painted and upgraded in 2023.

The Operations Director and Facilities Manager finalised an audit of the entire premises on 16-03-23 in relation to:
• Flooring and perished areas within the Nursing Home
• Painting requirements for walls, doors, door frames, radiators etc.
• Emergency Call Bell System – repairs / replacement of system
• Equipment and furnishings
• Lockable storage for Residents
• Window handles and restrictors

A repairs and capex schedule is now being put in place by the Group Operations Director and Group Facilities Manager, who will now source external contractors where required and attend to other issues in house with the local maintenance personnel.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control: Regulation 27 The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff. The sluice room storage has been reviewed and all items inappropriately stored have been removed. Staff debrief has taken place to ensure all staff are fully aware of the items permitted to be stored in the sluice. The Group Facilities Manager has reviewed the centre's storage and all boxes inappropriately stored on the ground in both communal and non-communal areas have been removed. Signage is in place to remind all staff that no items should be left on the floor in a manner that does not promote good cleaning habits and practices. The Clinical Director and Housekeeping Supervisor completed a visual inspection on 22-02-23 of the premises and areas of need highlighted for immediate action on the same date. A deep clean commenced in the centre on 25-02-23 and was completed on 13-03-23. This deep clean was overseen and managed by the CEO. A weekly deep clean of the kitchens and kitchenette areas are scheduled for Thursday 6pm to 9pm going forward. – A further steam clean of all ensuites, bathrooms and shower rooms commenced on 16-03-23 and is due to be completed on 21-03-23. Also, new daily and deep cleaning schedules are to be introduced with the household team on the week commencing 27-03-23 The treatment room was steam cleaned on 16-02-23. The issue with inappropriate mask wearing has been addressed with staff through debriefs and huddles as well as internal communications. The CNM2's will monitor adherence to this policy daily to ensure appropriate practices in place. Additional Signage added throughout the Nursing Home to support staff in relation to appropriate mask wearing and as a reminder throughout the day. The Chef met with the Management Team and a nominated dedicated deep clean day was set for the kitchen with additional supports rostered to ensure the deep clean completed weekly. Thursday has been agreed as the set day to deep clean all kitchen, satellite kitchens, dining rooms and associated catering equipment.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions:	

Regulation 28(1)(b) The registered provider shall provide adequate means of escape, including emergency lighting.

An external fire consultant has been contracted to undertake a full fire door audit and fire risk assessment of the centre (to include internal escape signage). Fire specialist on site on 20-03-23 and expected to complete audit and assessment by 30-03-23.

Separate contractor was on site on 20-03-23 attending to external lighting.

Regulation 28(2)(i) The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.

Our Preventative Maintenance Crew and our Main Contractor were on site week ending February 24th in relation to Fire Doors and fire related issues. Following this visit, some fire replacement fire doors have been ordered and are awaiting delivery.

As above, an external fire consultant commenced a fire door audit and fire risk assessment on 20-03-23

Broken window handles were fixed on 19-01-23, full audit of centre including windows was finalized on 16-03-23 and any other issues noted will be attended to

Regulation 28(2)(iv) The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.

All staff have received fire training on site. Additional fire training took place on 24-02-23 and 16-03-23

Fire drills take place every 2 months and the next drill is scheduled for 03-03-23, a further drill took place on 16-03-23 to facilitate new joiners

As above, an external fire consultant commenced a fire door audit and fire risk assessment on 20-03-23

Broken window handles were fixed on 19-01-23, full audit of centre including windows was finalized on 16-03-23 and any other issues noted will be attended to

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Regulation 5 (1) The registered provider shall, in so far as is reasonably practical,

arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).

Care planning training will take place with all staff in the centre.
All residents have a named nurse. This role will be revisited to ensure all resident have a dedicated nurse to review and update care plans.

In the absence of the DoN the CNM2 and CNM1s will continue to review and audit care plans.

The Compliance and Quality Manager will also review care plans on commencement of her role and in the absence of a DoN to ensure the care plans are reflective of the care needs of residents and capture the levels of care required.

Regulation 5 (3) The person in 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.

A resident admission checklist has been implemented in the centre which is signed off by the admitting nurse and checked by the CNM2 within 48 hours of admission- implemented 27-02-23.

Named Nurses for residents in the centre are currently reviewing all care plans to ensure they are reflective of the residents current status.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Regulation 8(1) The registered provider shall take all reasonable measures to protect residents from abuse.

Safeguarding Training took place in house on 24-02-24 and on 10-03-23, due to take place again on 27-04-23.

CNM2 to complete competency testing with staff to ensure familiarity post training
A residents meeting was held in house on 03-03-23 and safeguarding was an agenda item to ensure all residents are aware of their rights and the pathways to follow in the event they have concerns to be raised.

Residents' meetings to take place every 2 weeks with next meeting scheduled for 25-03-23 to ensure residents have ample opportunities to bring issues and concerns to management

Regulation 8(3) The person in charge shall investigate any incident or allegation of abuse.
Post inspection all incident and accidents were reviewed and incidents requiring notification have been submitted through the portal retrospectively.
Following discussions with a resident/family room changes were made to ensure increased observations. Currently in the centre, 2 matters are under investigation

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Regulation 9(2)(b) The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.

A full review of residents' activities is underway. The activity staff will meet with all residents in the centre to ensure that all their wishes and preferences are documented and residents choices are being met through the weekly activity programme. This will be completed by 22-03-23.

Once this information has been collected and disseminated the activity staff will amend the activity programme to reflect choices and commence smaller groups for residents with bespoke activity choices to ensure all residents are provided with meaningful engagements throughout the day/week.
Where residents decline to engage in this process and/or activities this will also be recorded and reflected in the care plan.

As indicated above safeguarding training has taken place and is due again in the centre to ensure staff are aware and knowledgeable as to what constitutes abuse. Staff debriefs and huddles have taken place on sight to ensure staff recognise that actions noted during the inspection do not uphold the resident's dignity.

Regulation 9(3)(a) A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

Call bell audits continue monthly. The CNM2 and Team leaders observe and visually audit the access to call bells daily. Access to call bells has been included in staff debriefs and huddles. Call bells and concerns highlighted in respect of them will also be discussed as an agenda item at the resident's forum meeting.

Residents' surveys to be recommenced on week commencing 20-03-23 to ensure residents have opportunities to bring issues and concerns to management

Regulation 9(3)(b) A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.

Doors to external gardens in Seabury have a key-pad for the security and safety of all residents. Doors to gardens in Estuary are key enabled. The key remains in this door at all times. All residents that have the ability to remember the keycode are given it and can access the gardens at any time. Residents with a dementia utilise the gardens with family and staff for their own safety. During the summer months these doors remain permanently open for ease of access for all residents.

Regulation 9(3)(d) A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.

Where appropriate all residents are included in decisions regarding the centre. Recent renovations in the centre involved residents in choices around textiles, colours and patterns.

Once the review of all residents activities choices, preferences and wishes is completed the Activities Team will review the activity planner and incorporate any new activities that residents wish to engage in. Alternatively, where more than one resident has a preference for an activity the activity team will strive to link these persons together to commence a club or group that meet to undertake the activity.

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 14(1)	There shall be a person in charge of a designated centre.	Not Compliant	Orange	02/05/2023
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	30/04/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/03/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	03/03/2023
Regulation 17(2)	The registered provider shall, having regard to	Not Compliant	Orange	30/03/2023

	the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.			
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	15/03/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/04/2023
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	02/05/2023
Regulation 23(c)	The registered provider shall ensure that management	Not Compliant	Orange	30/04/2023

	systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.	Substantially Compliant	Yellow	30/04/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	30/03/2023
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including	Not Compliant	Orange	30/04/2023

	emergency lighting.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/04/2023
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	20/03/2023
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Not Compliant	Orange	15/03/2023
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	30/04/2023
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have	Not Compliant	Orange	30/04/2023

	been assessed in accordance with paragraph (2).			
Regulation 5(3)	The person in 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.	Not Compliant	Orange	30/04/2023
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	20/03/2023
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	22/03/2023
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	22/03/2023
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other	Not Compliant	Orange	22/03/2023

	residents.			
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	22/03/2023
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Not Compliant	Orange	22/03/2023