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:	14 November 2023
Centre ID:	OSV-0000182
Fieldwork ID:	MON-0041072

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:	83

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 14 November 2023	08:55hrs to 19:10hrs	Helena Budzicz	Lead
Tuesday 14 November 2023	08:40hrs to 19:10hrs	Manuela Cristea	Support
Tuesday 14 November 2023	07:30hrs to 19:10hrs	Brid McGoldrick	Support

What residents told us and what inspectors observed

Residents spoken with throughout this unannounced inspection said they felt safe, secure and well cared for in Talbot Lodge Nursing Home.

Most of the residents and their relatives expressed satisfaction with the care they received. However, a concern was raised to the inspectors on the day of the inspection by a family member regarding communication from staff members to the families, quality of care and room cleanliness, appropriate staffing levels, and dealing with complaints. The inspectors also witnessed some of these issues on the day of the inspection and brought the concern to the attention of the management team. Inspectors were given assurances by the management of the centre that they met the family, and immediate action was put in place to prevent re-occurrences.

One of the inspectors arrived at the centre at 7.30 am and found that senior management was present. The inspector observed the nursing and handover process, and later in the day, following an introductory meeting, all the inspectors walked around the centre. The inspectors spent time in the various areas of the centre, chatting with residents and staff, observing staff provide care and support, and interacting with residents. Throughout the day, most of the residents were happy to speak with inspectors, and those who were unable to communicate were observed to be content with their surroundings. Residents said that staff were 'terribly kind', 'everyone is very nice', ' I am happy here, food is great, I have no concerns; there could be more activities, not much happening at times', and others said that they would like 'more outings' or 'movie nights'. This message was also conveyed in feedback from families, with one relative stating that 'staff are exceptional and the communication is great; there is nothing bad about this place and having access to regular physio a few times a week is excellent'. A relative described how the resident's friends continued to keep in contact and and would visit them on an evening, order takeaway pizza and play bridge together in the coffee dock.

Numerous visitors were observed coming to visit the residents throughout the day of this inspection. In advance of this inspection, one unsolicited information was received by the office of the Chief Inspector in respect of limited access to the centre during the times when there was no receptionist in the centre. This information was substantiated on the day of the inspection when one inspector experienced difficulties accessing the centre despite following the instructions as displayed at the door. There was a process in place with instructions on how to access the centre in the absence of the receptionist; however, this process was not effective on the day of the inspection. The inspector tried ringing the phone number displayed on several occasions; however, there was no answer. The management of the centre informed the inspectors that they would review current processes to ensure that the centre is accessible at all times.

The general environment and communal areas were observed to be well-maintained and visibly clean. However, some bedrooms and bathrooms were observed to be unclean, and inspectors found gaps in the completion of cleaning schedules.

The inspectors observed the residents' lunchtime meal service and spoke with residents eating in the dining room who said they were satisfied with their meals. The residents expressed satisfaction with the size, portions and quality of food. The meals served appeared wholesome and nutritious. However, inspectors observed different dining experiences between the units, where some residents were not offered choices or were waiting longer for the meals to be served. Inspectors observed residents in Estuary B unit, who had their meals in their bedrooms in this unit did not receive their food at the same time as the other residents. These residents had their lunches delayed and were observed to be served their soup at 13.30 hrs and lunch well after 14.00 hrs.

Inspectors observed residents chatting comfortably with staff members in the centre, and all staff greeted the residents by their names. Interactions observed were kind and courteous, and staff appeared to know residents' likes, dislikes, and personal histories well. Two activity staff members were employed by the centre to coordinate and provide activity programmes for residents. Residents were seen enjoying these activities in the sitting rooms. However, residents who did not like group activities and spent the majority of their day in their bedrooms were not observed to have much social interaction or access to meaningful activities other than television and radio on the day of the inspection. Formal activities were available to residents six days per week, with one resident saying that 'there was not much to do or look forward to at the weekend'.

The inspectors observed numerous activities throughout the day including ball playing, live music and singing, hairdressing, reading of rosary beads and a prayer group.

The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in place and how these arrangements impact on the quality and safety of the service being delivered.

Capacity and capability

Overall, the findings of this inspection were that some improvements had been made by the provider since the last inspection to enhance the quality and safety of care delivered. Notwithstanding the improvements seen in the areas of the temporary absence or discharge of residents, and recruitment of new staff members, there were some areas of non-compliance, which required further actions to ensure effective oversight of the service.

This was an unannounced inspection carried out by inspectors of social services to review compliance with the Health Act 2007 (Care and Welfare of Residents in

Designated Centres for Older People) Regulations 2013 as amended and to follow up on actions the provider had taken since the last inspection. The previous inspection in the centre had taken place in June 2023, and this was the fourth inspection carried out this year in the designated centre as a result of ongoing concerns in respect of the governance and management arrangements at the centre. There was a new person in charge on this inspection. This was the sixth person in charge appointed in the last two years. On the day of inspection, the person in charge was found to be knowledgeable of the regulations, and some additional support structures had been put in place both at the operational level and governance and oversight level.

The Talbot Lodge Nursing Home is operated by Knegare Nursing Home Holdings Limited and is registered to accommodate 103 residents, with 83 accommodated on the day of inspection. The care team in the centre was comprised of the person in charge, four clinical nurse managers (CNM), a team of nurses and healthcare staff, and administrative, catering, activities and household staff. Despite the improvements in the management structure and the provider's effort to recruit, there was a continuous vacancy for an assistant director of nursing (ADON), and, as a result, there continued to be an overreliance on the person in charge to provide on-call support over seven days a week. The inspectors were informed that the position for ADON was recruited and that the candidate was expected to start in a number of weeks. The person in charge reported to a Regional Manager who was in the centre two to three times a week and a Clinical Operations Director who visited the centre twice monthly. Both were present on the day of the inspection.

There were sufficient staff on duty to meet the needs of the 83 residents living in the centre on the day of the inspection. However, there were still a number of staff vacancies for various roles, including healthcare assistants, catering and household, as discussed under Regulation 23: Governance and management. The inspectors were satisfied, however, that outstanding shifts and vacancies were covered by the agency or by their own staff whenever required. Inspectors were informed that there was a continuous recruitment drive to fill all staff vacancies and that some posts have already been recruited into and were awaiting Garda Vetting clearance.

The provider was committed to providing ongoing training to staff. The training records showed high compliance with mandatory training and other relevant training, including fire safety, safeguarding vulnerable adults, manual handling, and infection prevention and control. An induction training template and competency assessment was developed to support the newly recruited nursing staff. There were arrangements for ongoing staff supervision through performance review processes and staff appraisals. However, increased supervision and training of clinical nursing practices and staff members' communication skills were required to ensure that residents were appropriately safeguarded and received a high level of evidence-based nursing care.

Staff files reviewed contained all the requirements under Schedules 2 and 3 of the regulations. Garda vetting disclosures in accordance with the National Vetting

Bureau (Children and Vulnerable Persons) Act 2012 were available in the designated centre for each member of staff.

There was evidence that the governance and management systems and oversight in the designated centre had been strengthened, as shown by the minutes of senior management governance meetings, regular audits and internal spot-check audits on environment and infection control completed. The provider's own audit had identified some of the findings of this inspection, including mealtime experience. However, further action was required to ensure effective clinical oversight and policies were implemented in practice, and that records were appropriately managed. This was particularly important as the centre had experienced a high turnover of staff in various roles. As per the evidence provided to inspectors on the day, there had been 23 new staff recruited and 32 leavers since June 2023. The inspectors followed up on providers' actions in respect of achieving compliance with fire safety by February 2024 and were informed that this was on track to be achieved.

Record-keeping systems comprised of electronic and paper-based systems. However, inspectors found that not all records were accessible in the centre as per regulatory requirements, and the registered provider was not able to account for the process of access, retention, storage, and destruction of records on the day of inspection. The system for storage and management of records, including clinical records, required full review. The inspectors were informed that records were stored in the centre for a two-year period, after which they were transferred off-site to another location. The manner in which records were stored was not appropriate and did not allow for safe access and timely retrieval of records.

Regulation 15: Staffing

There was a sufficient number of staff and skill-mix to meet the needs of the residents on the day of the inspection. There were a minimum of four qualified nurses on duty at all times.

Judgment: Compliant

Regulation 16: Training and staff development

While clinical supervision structures were in place, they did not ensure that all nursing staff were appropriately supervised so that residents were receiving a safe and sufficient level of care that was in accordance with each resident's needs and with relevant policies. The findings of this inspection identified that some additional training was required specifically in respect of clinical areas such as:

- Care of residents with a diagnosis of epilepsy.

- Assessment and monitoring of residents with Diabetes Mellitus to recognise hyperglycaemia.
- Training in the use of the Malnutrition Universal Screening tool (MUST).
- Assessment and care planning training.
- Unexplained bruising protocol and procedure were not available to staff.

Judgment: Substantially compliant

Regulation 21: Records

The registered provider did not ensure that all records set out in Schedules 2, 3 and 4 were kept in the designated centre and available for inspection and that those records were kept in a safe and accessible manner. While current records were well-maintained, information governance systems required full review to ensure older records were stored, maintained and destroyed in accordance with policy and regulatory requirements. There was also no register in place to account for the destruction of records, which was a requirement of policy.

Judgment: Substantially compliant

Regulation 23: Governance and management

The designated centre did not have sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. Although the centre was not at full occupancy, there were a number of vacancies in key-roles that continued to impact the full oversight and delivery of care. In addition, while the inspectors were informed that the position of assistant director of nursing (ADON) was filled and the candidate would start soon, this position had been vacant since July 2023.

While the staffing numbers and skill-mix were appropriate to meet the needs of residents on the day of the inspection, the staffing levels were not in line with the statement of purpose. There were vacancies for one full-time maintenance personnel, three for care assistants, one for catering staff and one for household staff.

The inspectors found that management and quality assurance systems that would ensure that the service delivered to residents was safe and effectively monitored remained inadequate in a number of areas, and consequently, most of the inspectors' findings on this inspection had not been identified by the provider through their oversight and auditing processes. This was evidenced by;

- Some clinical nursing practices, such as blood sugar monitoring and appropriate use of the Malnutrition Universal Screening Tool (MUST), were not in line with best-evidence guidelines, and local policies did not inform practice in all areas. The clinical oversight to monitor and recognise clinical incidents and implement learning from the incidents in practice was not adequate. The inspectors requested, on the day of the inspection, a clinical review of serious incidents to be carried out and the learning opportunities to be submitted to the office of the Chief Inspector.
- There was no local policy to guide nursing practices in instances of unexplained bruising found on the resident's skin. As a result, inconsistent practices that were not evidence-based were in place.
- From a review of the complaints log, inspectors found a complaint that had not been identified as a safeguarding incident. As a result, an appropriate safeguarding action plan was not put in place to minimise the re-occurrence of such incidents.
- Systems for the oversight of medication practices with respect to medication ordering, storing and returning were not always adequate and required further review.
- Further oversight of processes concerning the management of residents' finances required review. The registered provider's own internal management systems had failed to identify the findings discussed under Regulation 8: Protection and Regulation 9: Residents' rights.
- The management and oversight of staff resource allocation required review, especially with respect to meal times and the provision of activities across a seven-day period.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Inspectors found that the contracts of care clearly set out the terms and conditions of the resident’s residency in the centre.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge ensured that notifications of incidents or quarterly notifications were appropriately submitted. One safeguarding incident had not been identified and notified accordingly. This is being judged under Regulation 8: Protection.

Judgment: 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. Adequate systems, however, were not in place to ensure that these were implemented in practice, specifically in respect of

- Medication management policy,
- The policy on records management,
- The safeguarding policy and
- Infection prevention and control
- Monitoring and documenting of nutritional intake
- In addition, the risk management policy had not been reviewed in the past three years in line with regulatory requirements.

Judgment: Not compliant

Regulation 14: Persons in charge

The person in charge fulfilled the requirements of the regulations. They had the appropriate experience and qualifications.

Judgment: Compliant

Quality and safety

Overall, this inspection found that many residents reported a good quality of life in the centre, with caring staff and good access to activities over a six-day period. However, notwithstanding the positive feedback from residents, the findings of this inspection are that significant improvements are required in infection control and prevention regulation, food and nutrition, protection, assessments and care planning, medication management and residents' rights.

The inspectors reviewed a sample of care plans and found gaps in assessments and care planning arrangements. Furthermore, some care plans and associated care records were not person-centred and did not follow the best-evidence practices as discussed under Regulation 5: Individual assessment and care plan and Regulation 6: Health care.

Inspectors observed staff and resident interactions and resident records and found that where residents presented with responsive behaviours (how people with

dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment), these situations were well-managed by the staff team present. However, not all behavioural support care plans were updated following a behavioural incident, and some of the care plans were generic rather than person-centred. This is further outlined under Regulation 7: Managing behaviour that is challenging.

While inspectors observed overall some good infection control practices in the centre with respect to antibiotic usage monitoring, some areas where further improvements could be made were also identified, which are discussed further under Regulation 27: Infection control.

Inspectors reviewed the medication practices on the day of the inspection and found that some medicines management practices and procedures in the centre were not in line with professional nursing standards or local policy and had the potential to pose a risk to residents' safety, as discussed under Regulation 29: Medicines and pharmaceutical services.

While the provider had measures in place to protect residents from any form of abuse, the systems and arrangements in place to safeguard residents from abuse were not in line with best practice guidelines and required review. This is further discussed under Regulation 8: Protection.

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. Residents' wishes in relation to their preferred religious practices were recorded and respected. A local priest attended the centre on a regular basis to celebrate Mass. Other voluntary religious organisations came to pray the rosary with residents on the day of the inspection. However, further improvements were required with respect to residents' choices, rights and activities as discussed under Regulation 9: Residents' rights. In addition, a full review of the mealtime experience was required to ensure residents in each unit were supported with their meals in a timely and dignified manner.

Regulation 18: Food and nutrition

While inspectors noted some improvement in residents' dining experience since the last inspection, some further improvements were required with respect to the timely serving of food to ensure each resident's rights were upheld. This had already been identified by the provider's own audit system; however, at the time of the inspection, this action remained outstanding.

- The inspectors observed differences in the serving of meals. While in the Castle and Seaburry unit, the residents had a positive mealtime experience where food was served in front of them from hot bain-marie trolleys, the serving of the food in the Estuary C unit appeared chaotic, with some residents receiving their pre-plated food at one table and others waiting for a

long time while watching residents at other tables eating their food. One resident was observed by the inspector getting worried and asking, 'Where is my food?' while staff tried to reassure them that the food was on the way.
- Inspectors observed that residents' choices, specifically for residents on modified diets, were not upheld at the same time as for the rest of the residents. The food was pre-plated with sauce applied to the food in advance. The staff did not consult with these residents or ask them if they wanted to have sauce. Inspectors observed that residents who did not require assistance and were on a regular diet were either being asked in advance or had independent access to the sauces to help themselves if they wished to.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

The inspectors reviewed residents' records and saw that where the resident was temporarily absent from a designated centre, relevant information about the resident was provided to the receiving designated centre or hospital. Upon residents' return to the designated centre, the staff ensured that all relevant information was obtained from the discharge service, hospital and health and social care professionals.

Judgment: Compliant

Regulation 27: Infection control

Some further action was required to ensure that all infection prevention and control procedures were consistent with the National Standards for infection prevention and control in community services, 2018 published by HIQA. This was evidenced by;

- While an infection prevention and control (IPC) link practitioner nurse was identified to attend the next available course, at the time of inspection, there was no IPC link nurse to support the team locally in infection control prevention awareness.
- There were gaps in the cleaning schedules. Inspectors observed incorrect cleaning processes being used on the day of the inspection.
- The trolley used for cleaning was visibly unclean.
- The temporary closure on four sharps boxes was not engaged.
- There was no open date on the saline bottle used for dressing change purposes.
- There was water in the humifider on the oxygen concentrator, which was not in use. Stagnant water could pose a health and safety risk.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Medication management practices were not in line with best practices or local policy, which led to unsafe practices. For example:

- The systems for ordering and returning medications required review as the inspectors found that medicine was not returned in a timely manner when the resident no longer resided in the centre. The medication prepared to be returned to the pharmacy was not listed in the assigned return book and was not signed by the staff nurses. This data had been missing for a number of months, and the internal auditing system had failed to pick up on this issue.
- The medicine delivered from the pharmacy was observed unsafely stored in an unlocked box on the corridor, which posed a risk that the residents could access this medicine.
- One open antibiotic medicine with no opening date was still in the fridge, and therefore, it was difficult to account for how long it had been opened. An insulin pen was observed to be stored in the refrigerator after its first use, which was not in line with the manufacturer's instructions.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Action was required to ensure that care plans were reviewed and updated at regular intervals when there was a change in the resident's condition and, following a review by health care professionals, to ensure that they effectively guided staff in the care to be provided to a resident. For example:

- Care plans were not always updated to reflect the recommended treatment and advice given by health and social care professionals.
- Adequate detail was not contained in the care plan of a resident who may experience seizures. In the context of staff that may not know residents well, this detail would assist them in providing immediate and urgent care to a resident that may limit seizure activity.
- Some care plans were not updated following hospital admission when the residents experienced changes in their condition or a serious incident that affected residents' health and well-being.
- Inspectors observed that appropriate assessments and care plans were not in place in instances when unexplained bruising was found on the residents' skin.

Judgment: Not compliant

Regulation 6: Health care

Inspectors reviewed records for residents who experienced a change in their condition, and inspectors were not assured that residents consistently received a high standard of evidence-based practice in line with their assessed needs.

- For example, when a resident had a history of Diabetes Mellitus, the blood sugar levels were not monitored on a monthly basis as outlined in residents' care plans. Furthermore, blood sugar monitoring was not available for residents with a history of an incident with high blood sugar.
- Evidence-based assessment tools were in use; however, they were not appropriately applied. For example, residents at risk of malnutrition with a score of 2 in MUST (Malnutrition Universal Screening Tool) were not being weighed on a weekly basis as required.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

The inspectors saw evidence that residents were appropriately assessed following an incident of responsive behaviours. However, the care plans were not updated to reflect the learning and the actions following the incident. Some of the behaviour-supporting care plans were generic and not person-centred to allow staff to provide person-centred care.

Inspectors observed that a restraint-free environment was not always promoted as all doors to courtyards were key-pad locked in three units and were open in one unit only. This meant that the residents who were independently mobile or residents who smoked could not freely access the courtyards without the assistance of staff. These practices are not in line with the national policy and best practices.

Judgment: Substantially compliant

Regulation 8: Protection

Inspectors found that good practices were not in place to protect residents' finances. Knegare Nursing Home Limited held residents' funds in a business account

rather than a resident /client account. The findings of this inspection include the following:

- The pension agent application form required review as the pension agent's name documented on the form no longer worked in the centre.
- The accounting system did not account for invoices paid in and out for each individual resident.
- Residents did not receive statements advising them of funds available.
- Funds for a small number of deceased residents dating as far back as 2019 were not being timely returned to the state.
- Staff did not know how to access resident funds at weekends or out-of-hours if a resident wished to access the same.

Inspectors found that one safeguarding incident was not recognised or investigated, and adequate protective measures were not put in place to protect the resident and the staff member involved in the allegation from further re-occurrences as per the centre's safeguarding policy.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents were not provided with sufficient and adequate opportunities to engage in meaningful social activities that met their interests and capacities, especially over the weekend. While activity schedules were created, they were not flexible enough for residents to reflect their preferences, such as outings or movie nights. While activities had been reviewed and improved since the previous inspection, there was scope for further improvements as some residents and visitors reported that there was not much to look forward to at the weekend. Records confirmed that one day on the weekend, there were no activities available to residents.

Residents' right to access their finances was limited as the receipt of monthly statements was not provided to residents or their representatives.

There were difficulties accessing the designated centre outside of the receptionist's working hours, and the system in place was ineffective.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Not compliant
Regulation 14: Persons in charge	Compliant
Quality and safety	
Regulation 18: Food and nutrition	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Talbot Lodge Nursing Home OSV-0000182

Inspection ID: MON-0041072

Date of inspection: 14/11/2023

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The center has a strengthened clinical management team with the commencement of the ADON on 04-12-23 who supports the DON is overseeing the standard of nursing care provided to residents. In addition, there is a supernumerary CNM on duty daily to direct and monitor the quality of care provided to the residents - completed and ongoing. • A nurses competency assessment tool has been developed and commencement rolled out in Jan 2024 to ensure that all nursing staff are aware of the care required for the residents. This will be completed for all nurses by 01-03-24 and form part of the ongoing induction program of new staff nurse members going forward - ongoing. • All nursing staff are currently undergoing training in management of diagnosis of epilepsy and care of resident with diagnosis of Diabetes - completed and ongoing. • All residents with diagnosis of epilepsy and diabetes assessments and careplans have been reviewed by the onsite clinical management team and will be reviewed minimum 4 monthly and or sooner if there is a change in the residents' condition - completed and ongoing.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records:	

• The management have completed a review of the storage and management of records to meet appropriate storage -completed.

• The center has information governance systems and process of registering the destruction of records has been implemented in Jan 2024 - completed.

Regulation 23: Governance and management	Not Compliant

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

• The Governance & Management onsite team includes DON, ADON and CNM x 4. The regional manager and/or member of the senior clinical management team is onsite a minimum of 2 days per week to review clinical incidents as part of the monthly KPI review. A member of the clinical management team oversees any serious incident investigations to ensure that all appropriate learnings are identified and actioned - completed and ongoing.

• The group HR Manager has a robust recruitment plan in place to ensure that there are proactive solutions in place towards recruitment. This begins with a comprehensive review of staff Whole Time Equivalents (WTE) to identify vacancies, followed by posting jobs on various job boards. Leads are screened by the support office, converted into candidates, and contacted by individual homes. Interviews are arranged, and successful candidates receive an offer letter with a Garda vetting document. Garda vetting is conducted in adherence to regulations, and no employee starts until vetting is returned and reviewed by the home. References are requested, verified by the Director of Nursing or a senior management team member, and updated on HR electronic record system - completed and ongoing.

• New employees undergo mandatory training before starting, followed by a competency-based induction. Additional training is provided if needed. A 6-month probation period ensues, featuring regular check-ins to assess performance and offer support for successful probation completion - completed and ongoing.

• The position of maintenance person has been offered and this person will commence once GV is received. In the meantime, maintenance is managed in the center by utilizing the wider facilities and external contractors where required. There are significant SLA's in place with recruitment agencies and should agency be required the center makes every possible effort to avail of continuity of staff - completed and ongoing.

• A full suite of policies in line with Schedule 5 are in place and will be reviewed every 3 years and or in line with best practice changes - completed and ongoing.

• A clinical review of serious incidents has been completed by the PiC and submitted to

the office of the Chief Inspector - completed.

• A guidance document on the policy of the management of instances of unexplained bruising has been implemented and adherence is overseen by the PiC and Regional Manager as part of the G&M monthly review - completed and ongoing.

• All complaints are reviewed by the PIC, a member of the senior clinical management team oversees the complaints to determine and rule out any allegations of safeguarding. Complaints are discussed and shared at the heads of department meetings with learnings forming part of the staff debriefs. Complaints are monitored and trended as part of the monthly KPI report - completed and ongoing.

• The clinical management team have rolled out a biweekly medication audit to monitor appropriate and effective medication ordering, storing and returning of medications is in place - completed and ongoing.

• The management of the center have reviewed the management of residents finances in line with regulation and residents' and or their representatives are provided with their financial monthly statements.

• The pension agent application forms have been reviewed and the pension agent's name has been changed appropriately and returned from the Social Welfare department. The accounting system has been reviewed and now has clear transparency showing invoices paid in and out for each individual resident.

• A review of funds for a small number of deceased residents has been completed and where possible this has been returned and there is a robust system in place to reduce the risk of this occurring in the future - completed and ongoing.

• A process where designated staff can access resident funds at weekends or out-of-hours if a resident wished to access the same has been implemented - completed.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

• The center has an up-to-date schedule 5 policies and procedures in place and these will be reviewed in line with regulatory guidance going forward - completed and ongoing.

• Oversight of the policy implementation forms part of the monthly review and monitoring of clinical KPI's incidents and complaints as part of the G&M - completed and ongoing.

• As part of monitoring the adherence to policy, a biweekly audit system has been implemented for medication management - completed and ongoing.

• The center is developing an audit to monitor the compliance to policy on the management of records and this will be implemented in Q1 of 2024.

• The clinical management team have commenced safety pause/staff debrief sessions on safeguarding to ensure that all staff are aware of the contents of the safeguarding policy - completed and ongoing.

• The center has completed an IPC audit to include adherence to policy as part of the centers suite of audits - completed and ongoing.

• The risk management policy has been reviewed and updated accordingly in line with regulatory requirements- completed.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:

• A review of the mealtime service has been completed and a robust plan implemented to ensure choice if offered to all residents, use of sauce boats are in place, and residents sitting together receive their meals at the same time - completed and ongoing

• Lunch time for all residents across all areas commences typically @ 12.340 concludes by 13.30 ensuring residents lunches are not delayed. Mealtimes are delivered to residents within their preferences. This is enhanced by the implementation of allocations for staff to support and assist residents - commenced and ongoing.

• The PIC and ADON have completed toolbox talk on the dining experience to ensure that all residents are offered choice at mealtimes and their independence is promoted - commenced and ongoing.

• QUiS observational assessment tool is used to monitor the standard of mealtimes, and this will continue monthly by the clinical management team - commenced and ongoing.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• At the time of inspection, the center was waiting for a date for training to commence for an IPC link nurse practitioner, the nurse has been identified to complete this training - awaiting date.

• A new housekeeping supervisor commenced in role on 16th November 2023 and this person oversees the cleaning standards, the cleaning schedules and the relevant processes. All housekeeping staff have received further training on 12th December 2023 to ensure that appropriate cleaning processes are being completed.

• The housekeeping cleaning equipment has been reviewed, cleaned and a cleaning schedule has been implemented for this equipment. This is overseen by the housekeeping supervisor and the PiC.

• The Facilities project manager has completed an IPC environment audit in Jan 2024 and the action plan is currently being completed.

• The clinical management team have completed and IPC audit, staff debrief has been completed with learnings disseminated to include the necessity of closing sharps boxes and removal of water in oxygenators. The PiC will continue to complete checks on these areas as part of weekly governance - completed and ongoing.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• A review of the medication ordering and returning process has been completed. A robust system has been implemented to ensure that all records reflect ordering and returning activity. The PiC continues to audit the processes and the latest audit demonstrates improvement in this area - completed and ongoing.

• A staff debrief has been completed regarding the safe storage and a process implemented to ensure that once medications is delivered to the home, the nurse receives the medication, and it is immediately brought to secure storage area on each unit - completed and ongoing.

• A biweekly audit is completed on medications and staff nurses have been instructed on the correct storage of medications to include opening and labelling of antibiotics and storage of insulin pens - completed and ongoing.

• All nurses have completed medication management training at a minimum on an

annual basis and any medication errors are recorded to ensure learnings and actions to improve practice is implemented - completed and ongoing.

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:
• All nurses have completed training in assessment and careplanning and residents careplans will be reviewed in line with regulation - four monthly and or when the resident's health needs change. completed and ongoing.

• Following attendance by a member of the MDT, and or hospital admission, the CNM and ADON are assigned to review the residents' assessments and care plans to ensure that accurate information has been updated and shared with the wider care team - completed and ongoing.

• Residents careplans who are at a risk of seizures have been reviewed and enhanced with greater detail to reflect the steps required to assist the residents should they experience a seizure - completed and ongoing.

• A protocol for managing any incident of bruising has been implemented and any unexplained bruising is recorded, investigated, and managed as part of wound care management, this is overseen by the PiC and ADON - completed and ongoing.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• The clinical management team have completed a review of residents who have a history of Diabetes care plans and assessments to ensure that all details are present in the care plan and that the nurses are aware of the care required. A review of each residents' observations has been completed by the PiC and residents who require their blood sugar monitored monthly is in place and completion is being monitored by the PIC and ADON monthly - completed and ongoing.

• The PiC has completed a review of all residents MUST assessment scores and weekly weights are in place for residents who require same. The ADON has completed a toolbox talk with the nursing team to ensure that this continues and monitoring of this will be completed as part of the monthly KPI report - Completed and Ongoing.

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:
• Residents' behavior supporting careplans have been reviewed and enhanced with person centered interventions, these will reviewed and updated at a minimum 4 months and or when a residents needs change as per regulation. The standard of the person centered careplan will continue to be monitored as part of the auditing schedule completed by the PiC and ADON - completed and ongoing.

• The PiC is completing the restrictive practice self-assessment tool to include review of all doors accessing the external courtyard. In conjunction with facilities a review of the doors suitable access and egress for residents is being completed to determine suitable mechanism for promoting independent access and egress for residents.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The pension agent application forms have been reviewed and the pension agent's name has been changed appropriately and returned from the Social Welfare department. The accounting system has been reviewed and now has clear transparency showing invoices paid in and out for each individual resident.

• A review of funds for a small number of deceased residents has been completed and where possible this has been returned and there is a robust system in place to reduce the risk of this occurring in the future - completed and ongoing.

• A process where designated staff can access resident funds at weekends or out-of-hours if a resident wished to access the same has been implemented - completed.

• All staff have received training in safeguarding the resident, all incidents are reviewed by the PiC and discussed with the regional manager to ensure that any potential allegations of safeguarding issues are documented and reported appropriately. These are reviewed and reported as part of the monthly review report - completed and ongoing.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• A review of the activity calendar is underway to include movie nights and outings. Activity options is part of the residents committee agenda to provide residents with the opportunity to provide feedback on their choices and preferences.

• Assessment of all residents' individual preferences around their individual interests and capacities. As part of this any resident who wishes to remain in their room is recorded and displayed in the resident's rooms in pictorial format so as to inform all staff and encourage increased activity with the residents - completed and ongoing.

• The roster has been reviewed and there is a plan in place to ensure that there is a member of the activity team onsite daily, and a person is allocated to facilitate individual and group activity each day including Saturday and Sunday

• A process where designated staff can access resident funds at weekends or out-of-hours if a resident wished to access the same has been implemented - completed.

• Access to the center during out of hours reception is being monitored. The process in place includes a member of staff allocated to answer the phone to open the door during out of hours. There is a monitor on Seabury so the staff member can identify the person wishing to enter. This is being monitored daily to ensure effectiveness. The center has not received any recent complaints in this area.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	01/03/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	08/01/2024
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	08/01/2024
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	08/01/2024
Regulation 21(1)	The registered provider shall ensure that the	Substantially Compliant	Yellow	30/03/2024

	records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.			
Regulation 21(3)	Records kept in accordance with this section and set out in Schedule 3 shall be retained for a period of not less than 7 years after the resident has ceased to reside in the designated centre concerned.	Substantially Compliant	Yellow	30/03/2024
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	30/03/2024
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	30/03/2024
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	Not Compliant	Orange	30/03/2024

	effectively monitored.			
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.	Substantially Compliant	Yellow	30/03/2024
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Substantially Compliant	Yellow	01/02/2024
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the	Substantially Compliant	Yellow	01/02/2024

	environment and will ensure that the product concerned can no longer be used as a medicinal product.			
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	01/03/2024
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	01/03/2024
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	01/03/2024
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5,	Not Compliant	Orange	01/03/2024

	provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	01/03/2024
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	01/03/2024
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	08/01/2024
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation	Not Compliant	Orange	08/01/2024

	to the detection and prevention of and responses to abuse.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	30/03/2024
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.	Substantially Compliant	Yellow	01/02/2024