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:	21 June 2023
Centre ID:	OSV-0000182
Fieldwork ID:	MON-0039885

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:	85

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 21 June 2023	08:30hrs to 16:55hrs	Helena Budzicz	Lead
Wednesday 21 June 2023	08:30hrs to 16:55hrs	Frank Barrett	Support
Wednesday 21 June 2023	08:30hrs to 16:55hrs	Manuela Cristea	Support

What residents told us and what inspectors observed

The inspection took place in Talbot Lodge Nursing Home over the course of a day, and during this time, the inspectors took the opportunity to speak to residents and visitors to gain insight into what it was like living in the centre and get feedback about the service. Residents and visitors expressed that they were happy with their experience of the centre, with the centre's management and with the improvements made to the premises in recent months. However, a number of residents and visitors expressed their dissatisfaction with the activities provision at the weekends.

The inspectors arrived at the centre unannounced in the morning. Following an introductory meeting with the person in charge and assistant director of nursing, the inspectors conducted a tour of the premises. During the walkaround, the inspectors saw that residents were being assisted with personal care while some were up and relaxing in various day rooms. The inspectors noticed that the communal spaces and rooms in the centre were well maintained and homely. Some parts of the premises were in the process of being re-decorated. Many corridors were painted and looked clean. However, inspectors observed that the Castle unit was in need of refurbishment, and improvements were required regarding the painting and furniture replacement.

Residents' views and opinions were sought through resident meetings and satisfaction surveys, records of which were seen by the inspectors. Residents the inspectors spoke with gave positive feedback about the choice and quality of activities provided in the centre. Inspectors observed that residents enjoyed different activities during the day; they sang together in one unit while sitting outside in the garden areas. However, some residents and visitors said that 'there was not much to do during the weekend and the days could be long'.

Inspectors observed staff and resident interactions throughout the day and found that staff were familiar with residents and were kind and responsive to their needs. However, inspectors observed that some staff practices in the centre were task-oriented rather than person centered. This is discussed under Regulation 9: Residents' rights.

Inspectors observed the dining experience. The food served appeared to be wholesome and nutritious. However, the serving experience differed from unit to unit and was not equally presented as a relaxed and social occasion in all units. In one unit, staff were observed to not ask the residents about their preferences, or the music in the dining room was very loud, and there was limited interaction from staff. Inspectors observed that some residents had to wait a very long time to get their meals or get assistance from staff to ensure their nutritional needs were met. Inspectors also saw that residents who chose to remain in their rooms for their meals did not always have meals served in an appropriate manner. This is further discussed under Regulation 18: Food and nutrition and Regulation 9: Residents'

rights.

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

Capacity and capability

While inspectors acknowledge that the provider had made significant progress in improving the governance and management structure of the centre and in addressing non-compliances identified at the two previous inspections in January and March 2023, further action and improvements were still required in relation to fire precautions, governance and management, premises and residents' rights.

This was an unannounced risk inspection carried out by inspectors of social services to monitor compliance with the Heath Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The inspectors also followed up on the actions taken by the provider to address areas of non-compliance found on the last inspection in March 2023.

Knegare Nursing Home Holdings Limited is the registered provider for Talbot Lodge Nursing Home and is registered to accommodate 103 residents. The provider had strengthened the governance systems since the previous inspection and was striving to improve the quality and safety in the centre. They had appointed a regional manager and quality and compliance manager who oversaw the work of clinical and non-clinical staff. A new person in charge had been appointed since the last inspection, who was supported in her role by an assistant director of nursing, two clinical nurse managers, a team of nurses, health care assistants, activity staff and housekeeping staff. There was a clear line of accountability and responsibility throughout the nursing home in line with the statement of purpose. However, this was a new management team and further actions to strengthen oversight systems and enhance the supervision and support for staff in each unit were required as discussed under Regulation 16: Training and staff development and Regulation 23: Governance and management.

There had been a high turnover of staff in the centre in 2022, and inspectors found that the provider had ongoing recruitment efforts in place to maintain safe and consistent staffing levels. While some vacancies still remained, plans were already in place to replace nursing and care staff vacancies and ensure compliance with the regulations.

All staff had attended up-to-date training in areas, such as manual handling, safeguarding vulnerable adults, infection control responsive behaviours, and fire safety. The person in charge had good oversight of the uptake of training by staff.

Inspectors observed positive improvement in the oversights of Regulation 31:

Notification of incidents. Incidents were notified to the Office of the Chief Inspector in accordance with the requirements of legislation in a timely manner. Incidents were reviewed during the inspection, which were all managed appropriately.

Regulation 14: Persons in charge

The person in charge was working full-time in the post and had the necessary experience and qualifications as required in the regulations. They were found to be knowledgeable about the residents and staff and provided good leadership to the team.

Judgment: Compliant

Regulation 15: Staffing

Notwithstanding the recruitment campaign to fill in the vacancies in the centre, some gaps in the staffing levels and skill-mix continued to impact the care and service provided. For example:

- There was no additional activity staff allocated to work at the weekend. While this role was addressed by the care staff on an ad-hoc basis, no additional resources were put in place, meaning that care staff were taken away from their roles of direct care provision. Residents who spoke with the inspectors said that they had nothing to look forward to at the weekends, and the days were long and boring. There was a vacancy for a full-time position of maintenance staff which was evident in the many areas of the premises that were not sufficiently maintained or timely responded to.
- Inspectors observed delays during the mealtimes as there were not enough staff members available to assist residents.
- The centre had two vacancies for clinical nurse managers (CNMs) and staff nurses. It was observed that the CNMs were regularly working as staff nurses in the units. This led to a deficit in staff supervision and oversight of practices.
- There were gaps on the roster where household staff on planned leave were not replaced, and no contingency arrangements were in place.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The inspectors were not assured that the registered provider had appropriate staff supervision arrangements in place to ensure that care delivery was appropriately monitored and delivered and the facilities of the centre were appropriately maintained. For example:

- There was no appropriate supervision of the provision of meals to residents in their bedrooms and dining rooms.
- Inspectors saw many outstanding items in respect of the maintenance of the premises of the centre and a lack of supervision and oversight of the works to be completed in the centre.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The directory of residents contained the information required in line with specified regulatory requirements.

Judgment: Compliant

Regulation 23: Governance and management

It was identified on inspection that the designated centre did not have sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose (SOP). For example:

- The centre did not operate in line with the registered statement of purpose, which listed four clinical nurse managers (CNM) in the management structure to oversee a service of this size. There were two CNMs on the day of inspection who worked as staff nurses to compensate for vacancies.
- Inspectors found that the provider was in breach of condition 1 of its registration certificate as areas in the centre designated for residents' use, such as a communal bathroom for residents' use, were used as a staff facility.

Management systems in place required strengthening in order to ensure the service provided was safe, consistent and effectively monitored. The following required attention:

- The provider's oversight arrangements on staff supervision and allocation were insufficient to ensure effective supervision of residents, especially during mealtimes.
- Inspectors observed that oversight of the maintenance of the centre and services provided was not sufficient as the waiting times and finish work for some maintenance issues were lengthy and not appropriately completed.

Some facilities, such as bedrooms and bathrooms in the Castle unit, were in need of painting, and the residents' furniture was severely damaged and stained. Areas that required maintenance were appropriately logged and reported by staff; however, they were not followed up and completed.

- The registered provider had utilised the services of a competent professional fire safety consultant to identify fire safety concerns. The fire safety risk assessment, which includes a detailed fire door assessment, identified substantial risks relating to fire doors throughout the centre. The provider had begun the process of improving, repairing and replacing some doors throughout the centre. In consideration of fire safety matters identified during the inspection, the inspectors were not assured that appropriate management systems were in place to ensure the service provided was safe, appropriate, consistent and effectively monitored by the provider.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose contained all of the information set out in Schedule 1 of the regulations and accordance with the guidance.

Judgment: Compliant

Regulation 31: Notification of incidents

Inspectors reviewed records of all incidents and accidents occurring in the centre and found that relevant notifications had been submitted for all incidents specified in the regulations within the required time frames.

Judgment: Compliant

Regulation 32: Notification of absence

The person in charge was aware of the statutory requirements stated in the regulation that the provider should inform the Office of the Chief Inspector in writing in the event of the proposed absence of the person in charge from the centre.

Judgment: Compliant

Regulation 33: Notification of procedures and arrangements for periods when person in charge is absent from the designated centre

Inspectors were assured on the day of the inspection that the provider was aware of the notice to be given to the Office of the Chief Inspector in the absence of the person in charge from the centre. The centre had arrangements in place for the person who would deputise in the absence of the person in charge.

Judgment: Compliant

Quality and safety

Overall, the inspectors found that the provider was, in general, delivering a good standard of quality of service and nursing care; however, the gaps in oversight, as mentioned in the Capacity and Capability section, impacted the quality of life for the residents living in the centre. Further improvements were required in relation to the fire precautions, residents' rights, food and nutrition, documentation in relation to temporary absence or discharge of residents and managing behaviour that is challenging as detailed under the individual regulations.

The inspectors reviewed a sample of residents' care records and saw that a variety of validated tools were used to appropriately assess the residents. The overall standard of care planning had improved. Inspectors saw that the care plans were completed within 48-hours post residents' admission and were updated within the four-month time frame.

The provider promoted a restraint-free environment in the centre, in line with local and national policy. The provider had regularly reviewed the use of restrictive practices to ensure appropriate usage. However, some improvements were required in relation to the management of the episodes of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) as further detailed under Regulation 7: Managing behaviour that is challenging.

A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Staff spoken with inspectors demonstrated an appropriate awareness of their safeguarding training and detailed their responsibility in recognising and responding to allegations of abuse.

Modified and specialised diets, as prescribed by health professionals, were implemented and adhered to. As detailed in the first section of this report, action was required to ensure that food was appropriately served and that residents had a choice, as actioned Regulation 18: Food and nutrition.

Residents had access to local and national newspapers, television, Wifi and radio.

Residents had access to an independent advocacy service. However, further action was required to eliminate task-oriented practices occurring and to ensure that all residents' rights were protected and upheld. This is detailed further under Regulation 9: Residents' rights.

Inspectors reviewed precautions taken by the provider against the risk of fire. The provider has a works plan in place to address areas of concern from previous inspections and had utilised the services of a competent person to prioritise work relating to fire risk. While it was noted that some improvements had been made in relation to fire safety training of staff since the last inspection, ongoing issues relating to fire safety systems including emergency lighting, as well as layout plans which lack the necessary detail, all posed an ongoing risk to residents at the centre. In addition, a fire door assessment had been completed but was only made available to inspectors on the day of the inspection. This assessment identified additional risks which required timely and significant action from the provider.

Regulation 10: Communication difficulties

Residents who were identified on assessment as having communication difficulties were facilitated to communicate freely. Their communication care plans described the resident's communication needs, and the inspectors observed that care was being provided according to their care plan.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had adequate storage facilities in their bedrooms for their personal belongings. There was an effective and practical labelling system for residents' clothes in place.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents were not appropriately supervised during mealtimes, and there was not an appropriate number of staff to assist residents with the meals. There were delays in serving the food and assisting residents in their bedrooms and dining rooms. Inspectors observed that no interactions in relation to the serving of food upheld residents' dignity, such as choices not being consistently offered.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

The inspectors saw that when the resident returned from the hospital or was admitted to the centre, all relevant information about the resident was provided to the staff of the centre through the discharge letters, which were kept in the resident's file. However, a copy of the transfer letter when the resident was transferred to another facility was missing from the file.

Judgment: Substantially compliant

Regulation 26: Risk management

There was a risk management policy in place reflecting the measures and actions in place to control specific risks. There was evidence that serious incidents involving residents were recorded and investigated, and learning opportunities were identified.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider did not take adequate precautions against the risk of fire and did not provide suitable fire-fighting equipment, for example:

- There was a communications control cabinet situated behind the nurses' station. The nurses' station was open to the evacuation corridor. This activity increased the risk of fire in this area, and a fire in this area could prevent residents, staff or visitors from evacuating safely through the exit doors adjacent to the nurses' station.
- Inspectors could not be assured of the fire rating of the furniture in the smoking shed, which appeared to be made of light timber and would pose a fire risk if exposed to an ignition source, for example, a lit cigarette. The smoking policy at the centre referred to furniture being made of "fire retardant material".
- There were a large amount of used cigarette butts in a bucket and on the ground in the smoking area. This was contrary to a policy which stated that "cleaning staff shall empty ash-trays regularly". The staff smoking area was

also positioned in close proximity to the gas line serving the kitchen.

The registered provider did not provide adequate means of escape, including emergency lighting, for example:

- Layout plans posted on walls throughout the centre were not sufficiently detailed to guide the reader in the event of a fire evacuation. The floor plans did not identify the location of the reader and the primary and secondary evacuation routes. This could cause a delay and result in confusion during evacuation.
- Emergency lighting was not in place outside all emergency exit doors, for example, exit doors from the Castle unit.
- An exit door into the internal courtyard was difficult to open, and a hinge was broken on this door.

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

- There was a main electrical distribution cabinet on the evacuation corridor near the nurses' station. There were no appropriate fire safety containment measures in place at the cabinet.
- Issues throughout the centre were found with fire doors being damaged, not closing fully, and fire and smoke seals missing or damaged. For example:
    - The door from reception to the Seabury unit was sticking in the floor and, therefore, may not close fully in a fire situation.
    - Numerous bedroom doors had the intumescent strips painted over. This would make them less effective in the event of a fire.
    - Non-fire-rated hinges and ironmongery were found on fire doors throughout the centre. This would make them less effective at containing fires.
    - There were large gaps around the fire door to the cleaners' store in the Castle unit. This would be ineffective at containing fire and smoke in the event of a fire.
    - A sluice room door in the Estuary unit was damaged.
- A store room in the Estuary unit had a hole in the wall with exposed cabling. This would result in a lack of containment of fire and smoke in the event of a fire.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Residents' care plans were developed within 48-hours of admission, as per regulatory requirements.

Missing person assessment was completed for residents with the risk of wandering behaviour. The care plan detailed the measures to prevent residents leaving the centre unattended, and the emergency procedure outlined the procedure to be followed in the event of a resident being found to be missing.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Inspectors observed that where residents were exhibiting responsive behaviours (how residents with dementia respond to changes in their environment or express distress or pain), the clinical assessment tool to analyse any antecedent and describe the consequence of the behaviour and the supporting behavioural care plan was not completed following the most recent incidents.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had policies in place to guide staff in the safeguarding of vulnerable adults. Staff members demonstrated appropriate awareness of their responsibility in recognising and responding to allegations of abuse.

Judgment: Compliant

Regulation 9: Residents' rights

From the feedback from the residents and their families on the day of the inspection and from the documentation reviewed, inspectors observed that while activities were provided during the week, there were no activities provided for residents in accordance with their needs and preference to participate in group or individual activities during the weekend.

Furthermore, the inspectors observed some institutionalised practices in the centre while providing care for residents. For example:

- Some staff members used towels instead of clothes protectors for residents during their meal times and without asking permission prior to starting the tasks.
- Some staff members were not intentionally interacting with the residents during meal times and were standing beside them rather than sitting at their

eye level.
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	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 32: Notification of absence	Compliant
Regulation 33: Notification of procedures and arrangements for periods when person in charge is absent from the designated centre	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Talbot Lodge Nursing Home OSV-0000182

Inspection ID: MON-0039885

Date of inspection: 21/06/2023

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The activity roster is under review to ensure that activity staff are allocated to work at the weekend and to ensure there is a robust activity program for the residents at the weekend. • An additional maintenance person has been recruited and is awaiting Garda Vetting. • Meal service has been reviewed with a new system to be implemented from 08.08.23. To support supervision of mealtimes, the Medication administration times have been reviewed and changed to allow for RNs to supervise and monitor mealtimes on each unit. The nutrition policy will be reviewed to enhance the protected mealtime section to ensure the residents have the level of support required at mealtimes. • While the Recruitment campaign for an additional 2 CNMs and a new ADON is ongoing the CNMs are rostered supernumerary to support staff supervision and oversight of practices. • An additional staff nurse has been rostered supernumerary also for additional supervision until the CNM roles have been filled. • A member of the senior clinical management team will is onsite to provide support and guidance to the PIC at least 3 days per week currently. • There are weekly and monthly governance meetings to ensure all senior management is involved in the management of the Centre and that the PIC has adequate support and assistance. New staff nurses have commenced employment. This allows CNMs to be off the floor in a supervisory capacity for increased oversight. • All vacancies for housekeeping staff have been filled to date. This allows for adequate roster cover during planned leave.	
Regulation 16: Training and staff	Substantially Compliant

development	

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

• Meal service has been reviewed with a new system to be implemented from 08.08.23. To support supervision of mealtimes, the Medication administration times have been reviewed and changed to allow for RNs to supervise and monitor mealtimes on each unit.

• Since June 2023 an additional 4 staff nurses have commenced employment and a further 6 staff nurses have completed and passed their RSCI exams. These are currently completing mandatory training and will be due to commence induction training in house on 19.08.23.

• These new nurses were recruited in line with forward planning in the workforce to allow for any unexpected illness, annual leave, or resignations. Since the inspection 2 staff nurses have resigned. These additional nurses also allow for onsite training to be provided without having any impact on the roster or allocations and gives the nurses additional time to familiarize themselves with the residents and nursing home policies.

• While the Recruitment campaign for an additional 2 CNMs and a new ADON is ongoing the CNMs are rostered supernumerary to support staff supervision and oversight of mealtimes. The PIC will continue with the QUIS audits to identify any areas for improvement.

• An additional staff nurse has also been rostered daily in a supernumerary capacity for additional supervision and support.

• A member of the senior clinical management team is onsite a minimum of 3 days per week to assist and support the PIC. There is a robust auditing and meeting system in place to ensure all senior management are involved in the management of the Centre and available to support and assist the PIC.

• A new system has been put in place where the Facilities Manager meets with the local maintenance officer and PIC every two weeks to review maintenance logs in the home and discusses open issues within the home. A second maintenance officer has been recruited and is awaiting Garda vetting. The PIC will review the maintenance logs on a weekly basis to ensure the tasks have been addressed in a timely manner and follow up as necessary.

Regulation 23: Governance and management	Not Compliant

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

• Since June 2023, 4 staff nurses have commenced employment in the Centre. An additional 6 staff nurses have completed and passed their RCSI exams and are currently completing their mandatory training prior to commencing induction in the home. This has allowed for the CNMs to act in a supernumerary capacity for additional support and supervision on the units. This enhanced compliment of nurses ensures that the roster is covered during planned leave and there should be no requirement for the CNMs to be

rostered on the floor.
• A recruitment campaign is ongoing to recruit an additional 2 CNMs and a new ADON for the Centre to bring management levels back in line with the Statement of Purpose to ensure there is sufficient oversight in the Centre.
• A member of the senior clinical management team is onsite a minimum of 3 days per week to assist and support the PIC. There is a robust auditing and meeting system in place to ensure all senior management are involved in the management of the Centre and available to support and assist the PIC.
• The communal bathroom has been reinstated as a bathroom for resident use.
• The PIC will oversee staff allocations and rosters to ensure there is an adequate staff skill mix on each unit daily. Meal service has been reviewed with a new system to be implemented from 08.08.23. To support supervision of mealtimes, the Medication administration times have been reviewed and changed to allow for RNs to supervise and monitor mealtimes on each unit. As outlined above, with the successful recruitment of nurses there is a CNM rostered in a supernumerary capacity daily.

- The recruitment of an additional maintenance person will assist in maintenance issues being resolved in a timelier manner. The facilities manager will be on site fortnightly to oversee that issues are actioned and ensure the maintenance log is being managed appropriately. The PIC will review maintenance logs on a weekly basis to ensure tasks have been addressed. The provider is aware of the works required in the Castle unit and these issues will be addressed as part of the provider's capital expenditure plan. Extensive works have already been completed to some rooms in this unit over the last 12 months including re flooring, painting and furniture upgrades. The provider is aiming to have the refurbishment/furniture upgrades completed by 18.02.24.

• The Provider has an ongoing focus on fire safety, and since the March inspection has engaged the services of an external fire consultant, who completed a thorough inspection of the centre and provided a comprehensive report. The Provider is currently addressing the identified actions identified by the external fire consultant. This log of action items was available and presented to the inspectors during the inspection. Some of the identified works need to be completed by an external fire specialist and the provider is actively working to source contractors/ specialists to complete the work. Due to the demand for remedial fireworks across the nursing home sector, the provider is being advised by fire specialists that there are multi month wait times for contractors to be available to visit the site to access the works and further multi month delays for them to commence works. The Provider is aiming to have all fireworks completed by 28.02.24.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• To improve the interactions in relation to the serving of meals, Since the inspection in June 22 staff have attended training in understanding dementia with a particular focus

on communication and how to effectively communicate with someone living with a dementia and to ensure that choices is consistently offered.
• Guidelines for resident communication and enhancing mealtime experience are on display throughout the home.
• Meal service has been reviewed with a new system to be implemented from 08.08.23. To support supervision of mealtimes, the Medication administration times have been reviewed and changed to allow for RNs to supervise and monitor mealtimes on each unit.
• The nutritional policy will be reviewed to ensure that the protected mealtime section is sufficiently robust to guide staff in best practice. To identify areas for additional improvements and any other required staff training a series of QUIS and observational audits will be completed.
• Menu choices are collected in the morning by staff and given to the catering team. Additional courses are prepared in the event a resident might decide to change their mind or request an alternative.
• Clothes protectors are in place and used daily at mealtimes with resident consent.

Regulation 25: Temporary absence or discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:
• The national transfer document is available on the CRM system and will be used for all hospital transfers. This document will automatically be saved on the system in the individual resident's file.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The fire consultant who assessed the building identified the location of the communications control cabinet, as being partly mitigated as it is in a lobby area and away from bedroom accommodation. This unit will be encased in 1 hour fire resistant material currently awaiting external contractors to visit the nursing home to quote for these works, these works will then be scheduled based on the availability of contractors.
• The garden furniture has been removed and replaced with fire retardant furniture.
• The cigarette end bin/ bucket will be replaced with a more suitable cigarette end receptacle.
• A structural engineer has been engaged to review the fire compartmentation of the building and to produce floor plans and evacuation routes, currently awaiting their availability visit the nursing home to quote for these works, these works will then be

scheduled based on their availability.
• The Provider is currently awaiting an emergency lighting specialist to visit the nursing home to quote for these works, these works will then be scheduled based on their availability.
• The contractor has been requested to repair the exit door to the internal courtyard. The Provider is currently awaiting a time frame for completion.
• As above, the fire consultant who assessed the building identified this as being partly mitigated as it is located in a lobby area and away from bedroom accommodation. This unit will be encased in 1 hour fire resistant material currently awaiting external contractors to visit the nursing home to quote for these works, these works will then be scheduled based on the availability of contractors. The Fire Consultant has reported that ''the electrical installations appear in good order and electrical panels and distribution boards are tidy and secure with restricted access for unauthorised persons".
• A quote has been received by a fire door specialist and we are awaiting a date from them to visit the site to undertake the remedial repairs noted. The doors at reception to Seabury were replaced 24.07.23.
Estuary B the hole in the wall, has been repaired, the door is now fitted with a keypad lock to restrict access.

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:
• All residents that exhibit responsive behaviours have been reviewed by nursing staff and care plans are now in place for all residents. Care plans are being evaluated following incidents of responsive behaviours.
• ABC charts have been implemented for all residents who exhibit responsive behaviour, nursing staff have been advised to document any antecedent and consequence of their behaviour.
• The PIC and CNMs will review all ABC charts/ incident reports weekly to identify possible ''triggers' for behaviours and will ensure that care plans are updated accordingly, appropriate referrals made as required.
• PIC and CNMs will monitor this practice through their monthly audits. The Regional Manager will also monitor Key Performance Indicators which include responsive/ challenging behaviours and with the PIC determine patterns/ trends and where a need is identified put quality improvements measures in place.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: • The activity roster is under review to ensure that activity staff are allocated to work at the weekend and to ensure there is a robust activity program for the residents at the weekend. • Staff have been advised that towels are not appropriate clothing protectors, and they have been advised to use the available clothing protectors (with the residents' permission). Clothes protectors are available on each unit for residents if they wish to wear them. • All staff have been advised to be seated while assisting residents with meals. Additional seating is in place for staff in dining areas. The additional supervision of nurses and CNMs at mealtimes will provide oversight of the mealtime experience. • To date, 22 staff have received training in understanding dementia and how to communicate effectively with residents, particularly those living with dementia. • Guidance posters have been sourced, which act as a visual reminder for staff that mealtimes should be an enjoyable experience. • The nutritional policy will be reviewed to ensure that the protected mealtime section is sufficiently robust to guide staff in best practice. To identify areas for additional improvements and any other required staff training a series of QUIS and observational audits will be completed.	

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 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.	Substantially Compliant	Yellow	15/09/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	11/08/2023
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	15/09/2023

Regulation 18(3)	A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.	Substantially Compliant	Yellow	11/08/2023
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	04/08/2023
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.	Not Compliant	Orange	18/02/2024
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant information about	Substantially Compliant	Yellow	04/08/2023

	the resident is provided to the receiving designated centre, hospital or place.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	28/02/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	28/02/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	28/02/2024
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	08/09/2023
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in	Not Compliant	Orange	15/09/2023

	accordance with their interests and capacities.			
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.	Not Compliant	Orange	15/09/2023