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

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| 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: | 25 April 2024 |
| Centre ID: | OSV-0000182 |
| Fieldwork ID: | MON-0042293 |

## About the designated centre

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

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

**The following information outlines some additional data on this centre.**

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| 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 |
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| Thursday 25 April 2024 | 09:25hrs to 18:00hrs | Sheila McKevitt | Lead |
| Thursday 25 April 2024 | 09:25hrs to 18:00hrs | Kathryn Hanly | Support |

## What residents told us and what inspectors observed

Inspectors met with and observed residents throughout the day of inspection. They spoke with twelve residents about their experience of living in the centre. Residents said that they never waited long for assistance when they required it. They complimented the food and the helpful and considerate staff. Staff were observed assisting and interacting with residents in a friendly, caring and respectful manner.

Visitors were observed coming and going. Inspectors spoke with three family members who were very compliementary of the staff and the care they provided. Visitors confirmed that they could call to the centre at anytime.

Some residents attended the dining room for their meals while other residents chose to remain in their bedroom. Staff were allocated to support and supervise residents with their nutritional care needs within the dining room and in their bedrooms. Residents informed inspectors that there was a good choice of food available to them and that they could access food and snacks whenever they want. Water was available in residents' bedrooms.

Residents were supported to personalise their bedrooms, with items such as photographs and artwork to help them feel comfortable and at ease in the home. While some areas of the centre provided a homely environment for residents, significant improvements were required in respect of the premises and general maintenance within the centre. For example, inspectors observed that the décor in some bedrooms was showing signs of wear and tear. Surfaces and finishes including paintwork, wood finishes and flooring in a large number of resident bedrooms and ancillary facilities including housekeeping and sluice rooms were worn and poorly maintained and as such did not facilitate effective cleaning.

Barriers to effective hand hygiene practice were also observed. There were a limited number of clinical hand wash sinks available within close proximity to resident bedrooms in some units. Although alcohol-based hand-rub was available in wall mounted dispensers along corridors, they were insufficient and additional dispensers or individual bottles of alcohol hand gel were required to ensure alcohol hand gel was readily available at the point of care (directly outside or inside every bedroom).

Inspectors observed that a tagging system had been introduced since the last inspection, the purpose of this was to identify equipment and areas that had been cleaned. However, this system had not been consistently implemented. For example, inspectors saw that several items of shared equipment had not been tagged after cleaning and the tag was not removed after using some equipment. There were no guidelines in the use of this system and staff reported that they had not received any training prior to its implementation. The oversight and standard of environmental hygiene was poor. Inspectors observed a number of dirty rooms that

had been signed off as clean. In one instance, a bedroom vacated two days before to have a bowl with leftover porridge still on the table.

Residents were observed enjoying activities, however more residents could be included in the planned activities. For example, just two of the 83 residents were attending the morning art class.Inspectors observed a much better attendance at the music session in the afternoon. Furthermore, inspectors also observed that the doors to internal courtyards were locked throughout the day. This meant that residents could not access these outdoor spaces independently and relied on the assistance of staff.

All interactions observed on the day of inspection were person-centred and courteous. Residents generally spoke of exercising choice and control over their day and being satisfied with activities available.

The following two sections, capacity and capability and quality and safety will outline the quality of the care and services provided for the residents. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

## Capacity and capability

Talbot Lodge Nursing Home is operated by Knegare Nursing Home Holdings Limited and is registered to accommodate 103 residents, with 83 accommodated on the day of inspection. Overall inspectors found that the management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored were not sufficiently robust. This was a repeat finding. On four successive inspections in January, March, June and November 2023 inspectors had found insufficient and ineffective governance and management systems and that the provider had failed to ensure that the service provided was safe, appropriate, consistent and effectively monitored. Previous commitments given by the provider on the action plans from previous inspection reports had not been addressed within the timeframes set by the provider. For example, fire safety improvement works had not been progressed in line with assurances submitted in the provider's compliance plan to the June 2023 inspection. The repeated findings in respect of Regulation 23: Governance and management, Regulation 28: Fire safety; Regulation 8: Protection and Regulation 17: Premises demonstrate significant concerns in relation to the overall governance and management of the centre.

Inspectors identified that there was an unstable governance and management team. There had been an inconsistent and unstable organisational structure in this centre for some time and to date it had not stabilised. For example, the person in charge had just changed, this was the seventh change in this role within two years. Inspectors concluded that significant improvements were required in the overall governance and management of the centre to ensure there was effective oversight

of environmental hygiene within the centre. Details of issues identified are set out under regulation 23 and 17.

Inspectors also found that there continued to be insufficient assurance mechanisms in place to ensure that the premises were maintained to an acceptable standard. The provider was endeavouring to improve existing facilities and physical infrastructure at the centre through gradual upgrades and renovations of vacant rooms. However, there was no time bound action plan in place and progress to date had been slow with only three rooms renovated to date.

Infection prevention and control audits were undertaken by nursing management and covered a range of topics including staff knowledge, hand hygiene procedures, environment hygiene and sharps management. High levels of compliance were consistently achieved in recent audits. However, the findings of recent audits were not reflective on inspectors' findings on the day of this inspection.

There was a low level of prophylactic antibiotic use within the centre, which is good practice. However, the overall antimicrobial stewardship programme needed to be further developed, strengthened and supported in order to progress. For example, antibiotic consumption data was not routinely analysed or used to inform infection prevention practices. There was also an over reliance on the use of dipstick urinalysis for assessing evidence of urinary tract infection. This was contrary to national guidelines which advise that inappropriate use of dipstick testing can lead to unnecessary antibiotic prescribing, which does not benefit the resident and may cause harm including antibiotic resistance. Findings in this regard are presented under regulation 23.

Through a review of staffing rosters and the observations of inspectors, it was evident that the registered provider had ensured that the number and skill-mix of clinical and care staff was appropriate, having regard to the needs of residents and the size and layout of the centre. However, there were no full-time maintenance staff working in the centre and this post had remained vacant for over one year. Inspectors were informed that this post had been filled and staff were awaiting Garda Vetting clearance prior to taking up the role.

All staff had attended up-to-date training in areas such as manual handling, safeguarding vulnerable adults, infection control, responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment), and fire safety. Following the last inspection additional training had been provided to nursing staff in the care of residents with a diagnosis of epilepsy and in the assessment and monitoring of residents with a diagnosis of diabetes.

Documents reviewed including the staff roster, statement of purpose and a number of Schedule 5 policies required further review to ensure they reflected current practices.

## Regulation 14: Persons in charge

The newly appointed person in charge met the criteria. They demonstrated a good, clear under standing of their role and responsibilities.

Judgment: Compliant

## Regulation 15: Staffing

The provider had failed to provide sufficient maintenance staffing in the centre to ensure the premises internal and external spaces were maintained to a high standard.

Judgment: Substantially compliant

## Regulation 16: Training and staff development

There was an ongoing schedule of training in place to ensure staff had relevant and up-to-date training to enable them to perform their respective roles. However, improvements were required in oversight and supervision of environmental hygiene, the maintenance of the premises and the outstanding fire safety works to be completed in the centre.

Judgment: Substantially compliant

## Regulation 23: Governance and management

Management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored, as required under Regulation 23(c), were not sufficiently robust. This was evidenced by:

- There was insufficient oversight for residents' assessments and development of associated care plans. This is further detailed under Regulation 5: Individual assessment and care plan.
- Maintenance systems were not effective to provide a comfortable environment for residents living at the centre.
- The provider had introduced a tagging system to identify equipment that had been cleaned. However this system was not monitored and had not been consistently implemented at the time of inspection.

- Disparities between the finding of local infection prevention and control audits and the observations on the day of the inspection indicated that there were insufficient assurance mechanisms in place to ensure compliance with the National Standards for infection prevention and control in community services (2018).
- There was no evidence of ongoing and targeted multidisciplinary antimicrobial stewardship programme or quality improvement initiatives. This impacted the overall quality of antibiotic use within the centre and may contribute to antimicrobial resistance, Clostridioides difficile infection and other side effects.
- The provider had not nominated a staff member with the required link practitioner training and protected hours allocated, to the role of infection prevention and control link practitioner to support staff to implement effective infection prevention and control and antimicrobial stewardship practices within the centre.
- Repeat findings of non-compliance with Regulation 28: Fire precautions, Regulation 8: Protection and Regulation 17: Premises were found on this inspection.
- The registered provider had failed in delivering on actions and timelines committed to the Chief Inspector in previous inspection reports.

This is a repeated non-compliance.

Judgment: Not 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 fire safety policy.
- The finance management policy.

Judgment: Substantially compliant

## Regulation 21: Records

The roster shown to inspectors was not clear enough to show what staff were working what hours on the day of inspection.

Residents' records were not stored in a safe or accessible manner.

Judgment: Substantially compliant

## Quality and safety

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

Residents were supported to engage in activities that aligned with their interests and capabilities. An arts and crafts session in the morning was only attended by two residents. However, a music session took place in the afternoon and this was well attended by residents from all units. Residents had access to local and national newspapers, televisions and radios in their bedrooms and in the communal areas. Information regarding advocacy services was displayed in the reception area.

Inspectors observed improvements made to some areas of medication management. However, further improvements were required as evidenced under Regulation 29.

The inspectors viewed a sample of residents' electronic nursing notes and care plans. There was evidence that residents were comprehensively assessed prior to admission, to ensure the centre could meet their needs. Care plans viewed by inspectors were generally person- centred with improvements noted to care plans of those residents with epilepsy and diabetes. However, a review of a sample of urinary catheter and wound care plans found that sufficient information was not recorded in three care plans to effectively guide and direct the care of these residents. Details of issues identified are set out under regulation 5.

The National Transfer Document and Health Profile for Residential Care Facilities was used when residents were transferred to acute care. This document contained details of healthcare associated infections and colonisation to support sharing of and access to information within and between services. However, inspectors identified through discussions with nursing staff, that staff were unaware that residents from nursing homes were routinely screened for Carbapenemase-Producing Enterobacterales (CPE) on admission to hospital. As a result staff did not actively seek screening results when residents returned from hospital. Findings in this regard are presented under Regulation 25: Temporary absence or discharge of residents.

Improvements were required in respect of premises and infection prevention and control, which are interdependent. For example, surfaces and finishes including furniture and flooring in a large number of bedrooms were worn and as such did not facilitate effective cleaning. Inspectors also observed the inappropriate storage of

files and documentation in a store room leaving the room inaccessible. Weaknesses were also identified in the implementation of infection prevention and control standard precautions including sharps safety, environment, equipment and hand hygiene. Details of issues identified are set out under Regulation 27.

Inspectors reviewed arrangements in place to protect residents from the risk of fire at the centre. Limited progress had been made in relation fire safety since the June 2023 inspection, which resulted in ongoing non-compliance with regulation 28: Fire Precautions. For example, inspectors were not assured that the registered provider had taken adequate precautions against the risk of fire, including the containment of fire, the compartmentation of the building, maintaining appropriate means of escape and provision and maintenance of fire doors. These were repeat findings which were due to be addressed by 28 February 2024. Inspectors were informed that a comprehensive fire risk assessment was pending.

Inspectors were not assured that appropriate steps had been taken to ensure residents' finances were safeguarded from potential abuse.

## Regulation 11: Visits

There were no visiting restrictions in place and visitors were observed coming and going to the centre on the day of inspection. Visitors confirmed that visits were encouraged and facilitated in the centre. Residents were observed meeting visitors in private and in the communal spaces throughout the centre.

Judgment: Compliant

## Regulation 17: Premises

The registered provider failed to have regard to the needs of the residents at the centre and provide premises which are appropriate and which conformed to the matters set out in Schedule 6 of the regulations. For example:

- The centre was not well-maintained internally and externally. Parts of the centre were in a poor state of repair. Surfaces, flooring and furniture within a large number bedrooms was worn and poorly maintained and as such did not facilitate effective cleaning. For example, a number of occupied and unoccupied bedrooms had the wardrobe door covering ripped and hanging off the door.
- The environment had not been cleaned to an acceptable standard. For example several rooms that had been labelled "deep cleaned" were visibly unclean. Gaps were also observed in the daily cleaning records.

- Windows were dirty/unclean. For example, bird deposits were seen on some bedroom windows.
- A room that had been vacated several days earlier had not been deep cleaned. The bed was unmade and the resident's uneaten breakfast remained on the bedside table.
- Excessive amounts of files and documentation in store room number four left it cluttered and inaccessible.
- Residents' in twin bedrooms did not have access to a wash hand basin. They shared a bathroom containing a shower, toilet and wash hand basin with a third resident who occupied the single bedroom next door.
- Evidence of rodent droppings were visible in one unoccupied bedroom.
- Yellow stickers from COVID-19 pandemic remained on some communal area floors.
- Some bedroom doors did not have a number on the bedroom door, therefore it was difficult for residents to identify their bedroom.

This is a repeated non-compliance.

Judgment: Not compliant

## Regulation 18: Food and nutrition

Residents had a choice of food at each mealtime and access to snacks and drinks between meals. There were enough staff in the dining rooms to assist those residents who required assistance with their meals.

Judgment: Compliant

## Regulation 25: Temporary absence or discharge of residents

Nursing staff were unaware that all nursing home residents should be routinely screened for CPE on admission to acute hospitals. As a result, information about the resident's colonisation status was not actively sought by nursing staff prior to transfer back to the nursing home.

Judgment: Substantially compliant

## Regulation 27: Infection control

The provider had not ensured that infection prevention and control procedures were consistent with the National Standards for Infection Prevention and Control in community settings published by HIQA. This was evidenced by;

- Hand hygiene facilities were not in line with best practice and national guidelines in all areas of the centre. Dispensers or individual bottles of alcohol hand gel were not readily available at point of care. There was a limited number of dedicated hand wash sinks in the centre and the sinks in the resident's ensuite bathrooms were dual purpose used by residents and staff.
- Towels were observed hanging on rails in communal bathrooms, this practice increased the risk of cross-contamination.
- A range of safety engineered needles were not available. The inspector saw evidence (in the sharps disposal bin) that needles were recapped after use. This practice increased the risk of needle stick injury.
- Two cleaning trolleys were visibly unclean. Effective cleaning and decontamination is compromised if cleaning equipment is unclean.
- Canvas laundry collection bags on Castle unit were not washed after use. Inspectors were informed that these bags were washed weekly. This posed a risk of cross-infection.
- The detergent in two bedpan washers had expired and the detergent was not connected in a third machine. This may impact the effectiveness of decontamination in these machines.
- The two hydrotherapy bath jets were not effectively cleaned after and between uses. These baths are potentially a high-risk source of fungi and bacteria, including Legionella if not effectively decontaminated after use.
- There was water in the humifider on the oxygen concentrator in Seabury unit, which was not in use. This is a repeated finding. Stagnant water could pose a health and safety risk.
- Housekeeping staff were not using the appropriate cleaning products to clean body fluid spillages.

This is a repeated non-compliance.

Judgment: Not compliant

## Regulation 28: Fire precautions

The programme of works had not been progressed to address concerns raised in relation to fire detection, fire containment and fire doors throughout the centre. The registered provider did not make adequate arrangements for containing fires. Inspectors could not be assured of effective compartmentation within the building, for example: Outstanding issues included;

- The 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.
- Emergency lighting not in place outside all emergency exit doors. Non-fire-rated hinges and ironmongery on fire doors throughout the centre. This would make them less effective at containing fires.
- 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.
- 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.

This is a repeated non-compliance.

Judgment: Not compliant

## Regulation 29: Medicines and pharmaceutical services

Notwithstanding the improvements made to this area of care:

The dressing trolley contained single use dressings which were opened and half-used. This is not best practice and could pose a risk of cross-contamination as the dressing was no longer sterile.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and care plan

Based on the sample of care plans viewed, further action was required in individual assessment and care plans to ensure the needs of each resident are assessed and an appropriate care plan is prepared to meet these needs. For example:

- The urinary catheter (a flexible tube used to drain urine from the bladder ) change date was not documented in two urinary catheter care plans reviewed.
- There was some ambiguity regarding the dressing regime in one care plan reviewed.

- Visiting care plans were not in line with current visiting guidelines and several had not been updated following the COVID-19 pandemic.

Judgment: Substantially compliant

## Regulation 6: Health care

Residents had access to medical and allied heath care services. Residents' general practitioners (GPs) made site visits on a regular basis and each resident had a medical review completed within a four month time period, or sooner, if required. Residents also had their medications reviewed within a four month time-frame.

Judgment: Compliant

## Regulation 7: Managing behaviour that is challenging

Inspectors observed that a restraint-free environment was not always promoted as some doors to enclosed courtyards were key-pad locked. 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.

This is a repeated non compliance.

Judgment: Not compliant

## Regulation 9: Residents' rights

The rights of residents were upheld. There were opportunities for recreation and activities. Residents were encouraged to participate in activities in accordance with

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| their interests and capacities. Residents were viewed participating in activities as outlined in the activity programme. Residents with dementia were supported by staff to join in group activities in smaller groups or individual activities relevant to their interests and abilities. |
| Judgment: Compliant |

## Appendix 1 - Full list of regulations considered under each dimension

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

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Substantially compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 4: Written policies and procedures | Substantially compliant |
| Regulation 21: Records | Substantially compliant |
| **Quality and safety** | |
| Regulation 11: Visits | Compliant |
| Regulation 17: Premises | Not compliant |
| Regulation 18: Food and nutrition | Compliant |
| Regulation 25: Temporary absence or discharge of residents | Substantially compliant |
| Regulation 27: Infection control | Not compliant |
| Regulation 28: Fire precautions | Not compliant |
| Regulation 29: Medicines and pharmaceutical services | Substantially compliant |
| Regulation 5: Individual assessment and care plan | Substantially compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Managing behaviour that is challenging | Substantially compliant |
| Regulation 8: Protection | Not compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for Talbot Lodge Nursing Home OSV-0000182

## Inspection ID: MON-0042293

## Date of inspection: 25/04/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

## Section 1

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

**Compliance plan provider's response:**

| **Regulation Heading** | **Judgment** |
|---|---|
| Regulation 15: Staffing | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 15: Staffing:<br>Following the inspection, Garda vetting has been completed, and the vacant Maintenance post was filled and commenced on 26th April 2024. Additionally, the Registered Provider has committed to recruiting an additional 0.5 WTE Maintenance post. This position has also been filled and will commence June 04th thus ensuring a high standard of maintenance for both the internal and external premises.<br><br>Additional cover will continue to be provided where and if required by our Group's Facilities Manager and Group's Support Services Manager. | |
| Regulation 16: Training and staff development | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br>1. In our continued efforts to enhance oversight and supervision of environmental hygiene, the Director of Nursing (DoN), Facilities Manager and Support Services Manager have taken significant steps to improve the Centre's practices:<br>a. The DoN and HR Manager conducted a thorough review of our current training programs on May 03rd<br>b. A full walkabout of the premises was completed by May 27th to identify any gaps related to environmental hygiene and action plan implemented.<br>c. Based on the findings, new training modules are being developed to address specific areas of concern.<br>d. These new modules will be included in mandatory training sessions for all relevant departments. | |

e. Roles and responsibilities related to environmental hygiene have been clearly defined for the entire team.
f. A clear reporting protocol has been established for reporting any issues or instances of non-compliance.
g. The Housekeeping Supervisor has an allocated 16 hours of supernumerary time to focus exclusively on supervising the housekeeping staff. Added time will also enable the supervisor to provide more hands-on training and support to the housekeeping team, addressing any issues promptly and effectively.
h. Additionally, and to determine compliance and progress, audits will be conducted frequently by the Support Services Manager. Findings of these audits will be discussed with the relevant department and appropriate actions taken.
i. Further, the status of environmental hygiene improvements will be detailed and discussed at Governance and Management meetings to ensure transparency and accountability.

2. With the recent recruitment of a 1.5 WTE in the Maintenance Department, routine and preventative maintenance tasks will be completed on a daily basis, ensuring that our premises are kept in optimal condition. A timebound list of maintenance actions has been developed to guide the Teams efforts. A meeting was held on May 29th with the ADoN, Maintenance Department, Support Services and Facilities Manager to discuss the best approach to implementing this program.
In addition, the Register Provider continues his commitment to improve existing facilities and physical infrastructure through upgrades and renovations. Progress on maintenance and facility upgrades will be closely monitored by the Group's Facilities Manager and Support Services Manager on a weekly basis. In addition, the status of maintenance and facility improvements will be detailed and discussed during monthly Governance and Management meetings to ensure continuous, oversight and improvement.

3. A Fire Safety Consultant has completed a comprehensive Fire Safety Scope of Works. This plan prioritizes tasks based on urgency and compliance requirements, including all upgrades and repairs specified in previous inspections.

Progress of fire safety works will be monitored by the Group's Maintenance and Support Services Managers and any delays promptly addressed. A final inspection will be conducted by the Centre's Fire Safety Consultant once all works are completed to ensure everything meets the required standards.

Regular progress updates will be provided to the Chief Inspector during this period to ensure transparency, oversight and accountability.

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| Regulation 23: Governance and management | Not Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Registered Provider is committed to taking immediate and decisive action to rectify shortcomings highlighted under Regulation 23. Below, a brief summary outlines how the Centre will address each concern, with further detail provided under each individual Regulation:

1. Residents' Assessments and Care Plans:
o The local Management Team will conduct regular audits and quality assurance checks to ensure thorough and accurate assessments.
o Additional training and resources will be provided to staff involved in the assessment and care planning process. This will be completed by June 14th.

2. Maintenance Systems:
o A comprehensive review of our maintenance processes was conducted and completed by May 27th to identify areas for improvement.
o Necessary upgrades and repairs will be made to ensure a comfortable and safe environment for residents.
o We have established a proactive maintenance schedule to address issues promptly and prevent future problems.
o A full time Maintenance person has commenced April 26th and will be supported by an additional 0.5 Maintenance person, commencing June 04th.

3. Equipment Cleaning Tagging System:
o Staff received refresher training on May 29th on the importance of the tagging system and their responsibilities in its implementation.
o Regular checks and audits will be implemented to ensure compliance with the tagging system.
o A designated individual will oversee the monitoring of the tagging system and address any issues that arise.
4. Infection Prevention and Control:
o The DoN and Clinical Services Director will review and update existing infection prevention and control policies and procedures to align with national standards. This will be completed by June 07th.
o Refresher online staff training sessions on infection prevention and control best practices have commenced and will be completed by June 07th. This will be further complimented with face to face IPC training and will be completed June 20th.
o Robust monitoring and auditing processes will be enhanced to ensure compliance with infection prevention and control protocols. Full IPC Audit will be completed by June 07th and appropriate actions implemented.
o Starting May 15th, the local management team has conducted daily walkabouts to review staff practices related to infection prevention and control (IPC) and housekeeping. Immediate improvements were identified and addressed, with ongoing monitoring to ensure compliance. This initiative is complete and continues to be ongoing.

5. Antimicrobial Stewardship:
o Ongoing education and training will be provided to staff on antimicrobial stewardship principles and practices. This will be completed by June 07th.
6. Infection Prevention and Control Link Practitioner:

o A staff member has been identified and appointed for the Infection Prevention and Control Link Practitioner and will be supported in participating in Link Practitioner training at the earliest opportunity and avail of ongoing training as much as possible.
o Ongoing support and resources will be provided to ensure effectiveness in the role by the Group's Clinical Services Director.
7. Fire Precautions, Protection, and Premises Regulations:
o A thorough review of our fire safety procedures and protocols has been conducted.
o Staff training on fire safety precautions and emergency procedures was completed on May 03rd and further training scheduled June 06th.
o Identified deficiencies in fire precautions, protection, and premises regulations will be addressed promptly.

8. Fulfilment of Previous Commitments:
o Regular progress reporting will be provided to the Chief Inspector to demonstrate improvements progress and ensure transparency.

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| Regulation 4: Written policies and procedures | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
All policies and procedures are readily available to staff. Since the inspection, the Director of Nursing has reiterated these policies and procedures to all relevant departments, to promote understanding and ensure their implementation in practice.

Special attention has been given to Medication Management, Records Management, Fire Safety, and Finance Management, which has been supported by completing toolbox talks. This process will be accomplished by June 21st.

Ongoing training will be provided to all staff members in line with updates to any policies and procedures within the Nursing Home.

In addition, and to determine compliance with these policies and procedures, audits will be conducted frequently. The Director of Nursing will carry out these audits by reviewing relevant records, including incident reports, through direct observation, and by utilizing the appropriate audit tools. The results of these audits will be presented to the Management and Care Team as appropriate.

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| Regulation 21: Records | Substantially Compliant |

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| Outline how you are going to come into compliance with Regulation 21: Records:<br>1. Following recent inspection findings, the Centre has decided to revert to a paper roster system for managing staff attendance and scheduling. This change was effective from May 27th. The roster clearly demonstrates the working hours of all staff members on any given day. This measure has been implemented to ensure accuracy and compliance with inspection requirements.<br><br>2. Since the inspection a full review of storage records has been completed in the Nursing Home.<br><br>A methodical and chronological records management system has been implemented to ensure all archived records are easily identifiable and retrievable. All inappropriately stored items have been removed.<br><br>Regular audits shall be undertaken by the Management Team to determine compliance to this procedure. | |
| Regulation 17: Premises | Not Compliant |
| Outline how you are going to come into compliance with Regulation 17: Premises:<br>1. A full environmental audit was completed on May 27th by the Support Services Manager, Facility Manager, and Director of Nursing. Based on the findings, a detailed upgrades plan has been developed, including painting and redecorating, as well as upgrades and repairs to surfaces, flooring, and furniture. Progress will be monitored on a weekly basis and updates provided to the Regulator on a frequent basis.<br><br>2. A deep cleaning schedule has been enhanced ensuring all rooms labelled as "deep cleaned" meet acceptable cleanliness standards. Regular audits will be conducted by the local management team to verify compliance.<br><br>Any gaps identified in daily cleaning records have been addressed by ensuring all cleaning activities are logged accurately and consistently. This will be monitored by the Housekeeping Supervisor, who will conduct spot checks to ensure compliance.<br><br>In addition to the above enhanced practices, the Housekeeping Team have been provided with refresher training relating to deep cleaning. This was completed by May 27th.<br><br>3. Window cleaning has been scheduled, including the removal of bird deposits. This will be completed by June 30th.<br>4. Vacant rooms will undergo deep cleaning immediately after the collection of the residents' belongings. Once the deep cleaning process is complete, the rooms will be locked. The local management team will conduct frequent monitoring to ensure | |

compliance with this process.

5. The storeroom has been organised and decluttered by removing excessive files and documentation. A filing system has been implemented to maintain accessibility and order.

6. Each resident in the Centre have access to toilets, washing and bathing facilities within close proximity to their private accommodation.

7. Pest control service have been addressed and any evidence of rodent activity eliminated. Regular inspections are conducted by the Centre's Pest Control Company to prevent recurrence.

8. COVID-19 yellow stickers were removed from all communal area floors on the day of Inspection.

9. Clear and visible numbers will be installed on all bedroom doors to assist residents in identifying their rooms by June 04th.

| Regulation 25: Temporary absence or discharge of residents | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:
All nursing staff have been informed of the requirement to actively seek information about residents' colonisation status prior to their transfer back to the nursing home.

The National Transfer Document will be utilised by the Centre on transfer of the Resident from the Nursing Home to Hospital.

| Regulation 27: Infection control | Not Compliant |
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Outline how you are going to come into compliance with Regulation 27: Infection control:
1. Additional alcohol hand gel dispensers will be installed at the point of care in all areas of the Centre by June 30th.

We have recently increased the number of dedicated handwash sinks in the Centre with

the installation of three new units in different areas of the home. An additional clinical handwash sink will be installed in the Nurses Station on Estuary C Wing by June 12th.

Staff have been reminded that residents' ensuites are not to be used for dual purposes. The Housekeeping Supervisor will monitor this daily to ensure compliance.

2. Towels have been removed in communal bathrooms, disposable towels are available in each ensuite to minimize the risk of cross-contamination.

3. Safety-engineered needles have been procured and now used throughout the centre. Training has been reinforced on safe needle disposal practices by the Director of Nursing on May 15th.
4. A thorough cleaning and maintenance of all cleaning trolleys has been conducted immediately after the Inspection. Additionally, cleaning trolleys are now included in the daily cleaning schedule, with compliance monitored by the Housekeeping Supervisor.

5. Daily washing of canvas laundry collection bags has been implemented.

6. Expired detergent in bedpan washers has been replaced and the Maintenance Team will ensure all machines are properly connected and maintained on a frequent basis.

7. A rigorous cleaning protocol for hydrotherapy bath jets after each use has been established. The Housekeeping Supervisor will oversee the completion and monthly monitoring of this protocol.

8. During the RGN meeting on May 5th, the Director of Nursing reiterated the importance of ensuring that water is not left in the humidifier of the oxygen concentrator when not in use. The CNM Team will monitor this on a daily basis.

9. On May 27th, housekeeping staff received refresher training on the appropriate and correct use of cleaning products for body fluid spillages. This will be monitored daily by the Housekeeping Supervisor and overseen by the Support Services Manager. Any deviations from procedures will be addressed immediately.

| Regulation 28: Fire precautions | Not Compliant |
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Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. The communications control cabinet contains switches and signal cables which under normal circumstances do not require fire rated cabinets. While this has been confirmed verbally by our Fire Safety Consultant, we are awaiting formal confirmation of this is writing.

2. The scope of work for the emergency lighting upgrade has been completed by the Centre’s Fire Safety Consultant. The project has now been appointed to a qualified

contractor to carry out the necessary upgrades. The scope of this project includes the installation and upgrade of all emergency lighting outside all emergency doors. A timeline of October 31st has been scheduled for completion.

3. As part of the Centre's ongoing efforts to ensure the safety and compliance of the building, the Register Provider has engaged the services of a structural engineer to review the fire compartmentation and produce detailed floor plans. These plans will include clear evacuation routes and the location of the reader for each unit. A timeline of June 11th has been scheduled for review and completion.
4. Scope of works for fire door repairs has been completed by the Centre's Fire Safety Consultant. The Registered Provider has appointed a contractor to undertake these repairs and upgrades to include the following:

Upgrade of Non-Fire-Rated Hinges and Ironmongery;
Replacement of Intumescent Smoke Seals where painted over;
Necessary adjustments and repairs made to reduce gaps in the doors;
The door to the cleaner's store in the Castle Unit will also be included in these repairs to ensure it meets all relevant fire safety standards.

A timeline of December 31st has been scheduled for review and completion.

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| Regulation 29: Medicines and pharmaceutical services | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Subsequent to the Inspection, all dressing trolleys have been reviewed, and any opened or half-used single-use dressings discarded immediately.

Staff have been reminded of the importance of using single-use dressings as intended and the risks associated with using opened dressings. This concern was highlighted during the RGN staff meeting held on May 15th with the Director of Nursing and the HR Manager.

Regular checks have been implemented to ensure compliance with best practices regarding the use of dressings and any deviations addressed promptly by the DoN.

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| Regulation 5: Individual assessment and care plan | Substantially Compliant |

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| Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:<br>The review and update of care plans have commenced to ensure that all assessed needs are accurately reflected, and appropriate care plan is prepared to meet these needs, with a completion date set for June 30th.<br><br>Training and support is currently being provided to all RGN's to emphasize the importance of ongoing assessment and care planning, specifically in the areas of dressing regimes and catheter care, as well as for all emerging and changing care needs. This training has begun and will be completed by June 14th.<br><br>Refresher courses will be completed periodically to keep staff updated on any changes in care plan requirements and guidelines.<br><br>COVID-19 visiting care plans have been discontinued, except for use in precautionary situations.<br><br>Care plan audits are conducted monthly, and any findings requiring action are addressed and implemented immediately. | |
| 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:<br>The keypad locks have been assessed and subject to ongoing review to ensure the safety of all residents.<br><br>The Register Provider has ensured that all independently mobile residents are not subjected to the same restriction by giving them access to the keypad code. | |
| Regulation 8: Protection | Not Compliant |
| Outline how you are going to come into compliance with Regulation 8: Protection:<br>Following numerous correspondence requests from the Finance Department to the Centre's financial institution in 2023 and early 2024, and further engagement subsequent to the inspection, the Bank Relationship Manager for Talbot Lodge Nursing Home confirmed on May 1st, 2024, that the designated client account will now display 'resident | |

account' in the bank statement title.

This change ensures the proper identification and protection of resident funds.

## 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 |
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| 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 | 26/04/2024 |
| Regulation 16(1)(a) | The person in charge shall ensure that staff have access to appropriate training. | Substantially Compliant | Yellow | 29/05/2024 |
| Regulation 17(1) | The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of | Not Compliant | Orange | 30/09/2024 |

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| | purpose prepared under Regulation 3. | | | |
| Regulation 17(2) | The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6. | Not Compliant | Orange | 30/09/2024 |
| Regulation 21(1) | The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector. | Substantially Compliant | Yellow | 27/05/2024 |
| Regulation 21(6) | Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible. | Substantially Compliant | Yellow | 24/05/2024 |
| 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 effectively monitored. | Not Compliant | Orange | 31/05/2024 |
| Regulation 25(3) | The person in charge shall ensure that, in so far as practicable, a resident is discharged from | Substantially Compliant | Yellow | 10/05/2024 |

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| | the designated centre concerned in a planned and safe manner. | | | |
| Regulation 27 | The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff. | Not Compliant | Orange | 12/06/2024 |
| 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 | 11/06/2024 |
| Regulation 28(1)(b) | The registered provider shall provide adequate means of escape, including emergency lighting. | Not Compliant | Orange | 31/10/2024 |
| Regulation 28(2)(i) | The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. | Not Compliant | Orange | 31/12/2024 |
| Regulation 29(5) | The person in charge shall ensure that all | Substantially Compliant | Yellow | 15/05/2024 |

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| | medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the 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. | Substantially Compliant | Yellow | 21/06/2024 |
| Regulation 5(2) | The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre. | Substantially Compliant | Yellow | 30/06/2024 |
| 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 | Substantially Compliant | Yellow | 30/06/2024 |

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| | than 48 hours after that resident's admission to the designated centre concerned. | | | |
| Regulation 7(3) | The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time. | Substantially Compliant | Yellow | 10/05/2024 |
| Regulation 8(1) | The registered provider shall take all reasonable measures to protect residents from abuse. | Not Compliant | Orange | 01/05/2024 |