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:	07 October 2024
Centre ID:	OSV-0000182
Fieldwork ID:	MON-0045025

About the designated centre

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

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	74

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
Monday 7 October 2024	09:00hrs to 15:20hrs	Sheila McKevitt	Lead
Thursday 17 October 2024	15:50hrs to 16:10hrs	Sheila McKevitt	Lead
Monday 7 October 2024	09:00hrs to 15:20hrs	Manuela Cristea	Support
Monday 7 October 2024	09:00hrs to 15:20hrs	Sharon Boyle	Support

What residents told us and what inspectors observed

The feedback from residents spoken with on this inspection was overwhelmingly positive. They said that this was a good place to live, they felt safe and they were well cared for by staff.

Residents said the staff were 'excellent', 'kind' and 'always caring'. The names of some staff were repeated to inspectors and these staff were described as 'wonderful'. Residents went on to say that they really missed these staff when they were on days off or on annual leave. Most residents expressed satisfaction with the staffing levels, however on one unit, some residents said that they felt that there were not enough staff at times.

Staff were observed to deliver care and support to residents which was respectful. Residents were complimentary of the staff and management team and how they responded to feedback or suggestions. Residents said their voice was heard and when they raised concerns they were followed up. One resident told inspectors that there was an issue with the supply of continence wear; inspectors followed up on this, they were informed and saw that a supply of continence wear had been delivered on the day of this inspection.

Following receipt of an application to vary the wording restrictive condition 4 placed on the centre certificate of registration, the inspectors went to view the refurbished unit named Estuary C to determine if it had been fully refurbished and ready for occupation by residents, inspectors also viewed Castle unit. The inspectors walked around two of the four units with the person in charge and a senior health care assistant. The inspectors inspected all the bedrooms in Estuary C. The bedrooms on this unit had been refurbished to a satisfactory standard and now met the regulatory requirements. However, inspectors observed that the walls of the corridors, communal room doors, hand rails and some areas of flooring had not been upgraded and continued to show signs of damage and wear and tear.

Inspectors were shown a plan for the full refurbishment of this unit, which had a completion date of 24 November 2024. Therefore, the refurbishment of Estuary C was not completed as stated in the provider's application to vary condition 4 of the registration. One inspector returned 10 days later for a second day of inspection and saw evidence that refurbishment of the communal areas was in progress; the walls of most of the corridors had been painted, with just one outstanding, that was prepped for painting, the communal room doors and hand rails had all been repainted, and some of the corridor flooring had been upgraded. There were two corridor floors that had been prepped for polishing. The two completed corridors appeared clean and shiny, with no evidence of marks or old paint.

The inspectors observed visitors coming to and from the centre throughout the day. They visited residents in their bedrooms and in the day rooms. Residents said that there was a varied schedule of activities available for them to participate in

throughout the day. Inspectors spoke with a group of residents enjoying morning coffee in the front reception. They said it was an enjoyable experience where they could chat in a quiet and relaxed setting. The table was observed to be set with high quality crockery and the confectionery and beverages served appeared appetising.

The inspectors observed the lunchtime experience and found that the meals provided appeared appetising. Residents were complimentary about the food served and confirmed that they were always afforded choice. The menu was displayed and the tables were laid out with cutlery and condiments for the residents to access easily. The inspectors observed staff discreetly offering encouragement and assistance to residents.

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

Capacity and capability

This unannounced inspection was carried out following receipt of an application to vary the wording of restrictive condition 4, placed on the centres certificate of registration in July 2024. The application form and additional information submitted by the provider were reviewed by inspectors prior to the inspection. The application form stated that the unit named Estuary C had been fully refurbished and the provider wished to recommence the admission of residents to the newly refurbished unit.

The inspectors also followed up on the actions taken by the provider to address significant issues of non-compliance identified during the previous inspection in July 2024 which had led to a restrictive condition being placed on the centre's certificate of registration.

Talbot Lodge Nursing Home is operated by Knegare Nursing Home Holdings Limited and is registered to accommodate 103 residents, with 76 accommodated on the day of inspection. The inspectors noted that the provider had come into compliance with Regulation 34: Complaints. However, Regulation 17: Premises remained non-compliant while three regulations, Regulation 5: Individual assessment and care plan, Regulation 7: Managing behaviour that is challenging and Regulation 29: Medicines and pharmaceutical services had moved from substantial compliance to being found non-compliant. The remaining regulations reviewed remained in substantial compliance.

The governance and management team had remained stable since the last inspection. The management team were meeting on a regular basis to discuss governance issues within the centre. Monitoring systems had been established but were not found to be fully effective particularly in relation to the premises,

medication management, assessments and care plans and the management of behaviour that challenge.

The centre was adequately resourced with adequate staffing levels to ensure the assessed needs of residents were met.

Documents reviewed included the records of complaints and Schedule 5 policies. The medication management policy was not implemented in practice and did not reflect best practice.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

The provider had submitted an application to vary the wording of restrictive condition 4 placed on the centre's certificate of registration in July 2024. The application form, fee and additional information submitted by the provider were reviewed prior to the inspection.

Judgment: Compliant

Regulation 15: Staffing

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

Judgment: Compliant

Regulation 23: Governance and management

The management systems in place to ensure oversight of practice in a number of areas were not sufficient to ensure a safe effective service was provided at all times, including the following:

- The tools used in the established auditing system did not ensure that all the areas of practice being audited were covered. For example, the medication management audit tool did not ask about the temperature of the medication store room, which was observed to be excessively warm on the day, as well as in the preceding days of the inspection. In addition, the provider's own internal audit systems had failed to identify that medication was not administered safely and in line with local policy and evidence-based practice.

For example, inspectors found that medication rounds took more than two hours from the prescribed times of medicines.

- The standard of nursing documentation was not in line with best practice guidelines. Documentation observed did not meaningfully informed the care provided. The oversight of residents' assessments and care plans was not robust as further detailed under Regulation 5.
- Notwithstanding some of the improvements observed by the second day of inspection, there were areas of the inside of the building which were not consistently maintained in a good state of repair, as further described under Regulation 17.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure in place, which was displayed throughout the centre. The records reviewed showed that complaints were recorded and investigated in a timely manner. For those complaints that were closed, the inspectors saw evidence that the complainants had been informed of the outcome of the investigation and their level of satisfaction with the outcome was recorded.

Judgment: Compliant

Regulation 4: Written policies and procedures

Policies and procedures in accordance with Schedule 5 of the regulations, were in place and were reviewed regularly. However, the medication management policy did not reflect current research based practices.

Judgment: Substantially compliant

Quality and safety

Inspectors found that residents living in the centre were, in general, supported to sustain a good level of overall health and wellbeing, and they reported a high level of satisfaction with the care received in the centre. However, the management of individual care planning, restrictive practices and medication management was not not in line with regulatory requirements. In addition, non-compliance was also found in relation to the premises and fire safety.

The refurbishment of Estuary C was found to be incomplete. Although the bedrooms in Estuary C had been refurbished to a satisfactory standard and met the regulatory requirements, the walls of the corridors, communal room doors, hand rails and some flooring had not been refurbished. These areas remained in a poor state of repair on day one of this inspection. However the refurbishment plan was in progress on the second day of inspection and the improvements made to the areas upgraded were evident. By the second day of inspection, the premises appeared to be in a better state of repair. This is further outlined under Regulation 17: Premises.

In respect of fire safety, the provider had an action plan in place to achieve compliance by 31st of December 2024, as part of a restrictive condition of registration. Inspectors reviewed some of the fire safety actions taken by the provider and found that they had made good progress, with further works required in respect of containment, fire doors and detection. For example, the provider ensured that appropriate arrangements were in place for maintaining and testing of all fire equipment. Weekly and daily fire safety checks were now completed in line with the centre's own fire policy. Records evidencing the fire safety checks, and the fire alarm tests were complete. The oversight systems for fire safety and the provider's own internal monitoring systems had improved significantly.

Staff had been appointed as fire wardens and they had received specific training to ensure that they could co-ordinate staff and residents to follow safety procedures in the event of a fire. Inspectors spoke with staff who provided assurance that they had received further fire training and were confident that they could implement the principles of this training in practice. They demonstrated that they had the knowledge and skills to safely evacuate all residents from one compartment to another area of safety in a timely manner.

Fire drills were being completed on a weekly basis. Inspectors saw that the records of these fire drills were comprehensive. There was evidence that staff had trialled different evacuation scenarios, including of the largest compartment with the lowest numbers of staff available. For example, eight staff were involved in practiced fire drills which reflected the night time staffing levels.

The storage of medicines had improved, however, inspectors found thast medicines continued to be stored at inappropriate temperature, which posed a risk to the efficacy of those drugs. Non compliance in medication management practices are outlined under Regulation 29: Medicines and pharmaceutical services.

The inspectors reviewed a sample of residents' pre-admission assessments, risk assessments and care plans and found that residents' needs were not always informed by detailed person-centred assessments and care plans. Inspectors found that the pre-admission assessments were not completed in detail. Some residents did not have appropriate risk assessments completed and as a result, the information in the care plans did not reflect the residents preferences and individual routines. resident's care supports and interventions were not developed to meet residents needs and did not ensure that the care provided was person-centred.

There was a restraints register in place and auditing of restrictive practice was occurring. However, a restraint register conflicted with what was observed to be in use on the day of inspection. On review of resident documents in relation to restraint use, it was noted use of restraint was not being used appropriately and was not in line with national policy and the registered provider's own policy. This is further discussed under Regulation 7: Managing behaviour that is challenging.

Regulation 17: Premises

Notwithstanding the refurbishment that had been completed in the bedrooms in Estuary C, the inspectors found that Estuary C did not comply with the requirements of this regulation, due to the following:

- the corridor walls, communal room doors, hand rails and areas of flooring remained heavily damaged and scuffed in Estuary C on day one of this inspection.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The management of medicines in this centre was not in line with the requirements of the regulations for the following reasons:

- The temperature in the medication room in Castle unit was reading 27 degrees centigrade and in Seabury treatment room the temperature had been recorded on three separate days in September as being at 26 degrees centigrade. This posed a risk that medication was not stored safely and in line with manufacturer's directions.
- The person in charge did not ensure that all medicinal products were administered in accordance with the direction of the prescriber. For example, one resident was observed being administered their medications in a crushed format, however they were not prescribed to be administered as crushed. Medication was prescribed to be administered at 8 am. On two of the units inspectors observed medications continuing to be administered by 10 am and staff confirmed that this was a regular occurrence. Such practices were not in line with local policy or best practice.
- A number of single use dressing were found open and partially used in two treatment rooms. This posed a risk of cross-contamination and was not safe practice. These dressings were disposed of by staff at the inspectors' request.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Care plans were not always developed following a comprehensive assessment of a residents needs. For example:

- A number of residents had care plans in place but no risk assessments to inform those care plans. For example, residents with restraint in use had no risk assessment.
- Care plans were not always reviewed and updated to reflect the current needs of residents. Historical and generic information were contained in some care plans which could potentially cause confusion as they did not reflect residents' current needs and the care required for the specific problem was not clear.
- Some care plans were not reviewed and updated following the resident being reviewed by a health care professional or following an accident. This meant that care plans did not reflect resident's current needs based on the latest assessment.
- Pre-admission assessments and comprehensive assessments reviewed were incomplete. Information in respect of resident's infectious status was did not inform the current plan of care for that resident.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

The registered provider had failed to ensure that restraints were used in accordance with national policy. For example:

- Restraint risk assessments reviewed did not provide an outline of what, if any, less restrictive options were trialled before equipment such as bed rails were implemented.
- Care plans for residents who were exhibiting responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) stated that all incidents of challenging behaviour were recorded on ABC chart (Behaviour Chart for challenging behaviour). However, on review, many of these charts were incomplete for those residents who had displayed such behaviours.
- Care plans for residents who were exhibiting responsive behaviours did not identify possible triggers and/or interventions that should be considered in supporting the resident during these episodes or to prevent such incidents occurring.

- Cigarettes were not documented as a restraint in the restraint register, although some residents' cigarettes were held by staff on their behalf.

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	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Compliant
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant

Compliance Plan for Talbot Lodge Nursing Home OSV-0000182

Inspection ID: MON-0045025

Date of inspection: 07/10/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Not Compliant

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

• In response to the recent findings, the medication management audit tool has been updated to include temperature recordings for the medication storage rooms, ensuring compliance with safe storage standards. A scheduled solution will address the excessive heat observed in these areas, with an electric fan equipped with a thermostat to be installed in each room, set for completion by December 13th. This will maintain temperatures within safe limits, ensuring medication efficacy and safety.

Additionally, the medication policy has been revised to adjust local administration times, with morning rounds now starting at 9 am instead of 8 am. This change allows for a thorough morning handover, minimizing interruptions to medication rounds and supporting best practices for safe administration within the appropriate timeframes. Further details on these improvements are provided under Regulation 29 - Medicines and Pharmaceutical Services.

• In response to the identified gaps in nursing documentation, a comprehensive review of all residents' care plans and assessments is underway to ensure alignment with best practice guidelines. This review, currently 45% complete, focuses on enhancing the quality and accuracy of documentation to ensure it meaningfully informs the care provided. This is scheduled for completion by November 30th.
Additionally, oversight mechanisms have been strengthened to support thorough and up-to-date assessments for each resident, as further detailed under Regulation 5 in the report.
• The Estuary C Unit underwent a complete refurbishment, updating both private bedrooms and shared areas. Following bedroom enhancements, improvements were made to communal spaces, including fresh paint for corridor walls, doors, skirting, and handrails. Flooring was polished, with any damaged sections replaced, achieving a renewed and inviting atmosphere. The project was finalized on October 23rd, fully revitalizing the unit.

Regulation 4: Written policies and procedures	Substantially Compliant

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

The Director of Nursing reviewed and updated the Medication Management Policy on October 25, 2024, shifting the morning medication administration time from 8 am to 9 am. This adjustment allows staff nurses adequate time to complete the morning handover while ensuring a full two-hour window for uninterrupted and timely medication administration.

To verify the effective implementation of this updated policy, an ongoing auditing and daily walkaround process has been established, conducted by members of the Senior Management Team. This process ensures that these adjustments are consistently reflected in daily practice. Implementation was completed as of November 8, 2024, with continued daily monitoring.

This is further detailed under Regulation 29 - Medicines and Pharmaceutical Services.

Regulation 17: Premises	Not Compliant

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

The refurbishment of Estuary C Unit has been comprehensive, covering both individual bedrooms and communal areas.

Following the completion of bedroom upgrades, attention shifted to enhancing shared spaces. This included repainting corridor walls, communal room doors, skirting, and handrails for a fresh, updated appearance. All flooring was polished to a high standard, and any damaged sections were replaced.

The Estuary C Unit refurbishment project reached completion on October 23rd, resulting in a full rejuvenation of the unit.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

• The Group Facilities Manager has scheduled the installation of a 6-inch electric fan with a thermostat in each Medication Room by December 13, 2024. This system will maintain temperatures within the set safe range, ensuring full compliance with temperature control standards for medication storage.

In the interim before the ventilation installation, staff nurses are required to check and document both medication room temperatures three times daily. To support compliance, the DoN, PiC, or ADoN will review these temperature logs during daily walkarounds and promptly address any deviations from the safe range.

• The Medication System underwent a comprehensive review to ensure that all resident data is current, including verification that crushed medications are appropriately prescribed for residents who require them. As part of this initiative, the Person in Charge held meetings with all staff nurses to reinforce the importance of following accurate procedures and prescriptions during medication administration. All nurses completed training and a further debrief on November 5, 2024, reinforcing these practices, and were provided with a copy of the updated Medication Policy for reference.

Given that this was a newly implemented system at the time of the Inspection, a daily tracker was introduced to capture any inaccuracies and ensure immediate corrections. This tracker was maintained for one month to support a smooth transition, and the system is now fully operational. Completion date: November 5, 2024, with ongoing monitoring.

• To ensure medication administrations occur within a two-hour timeframe, the Director of Nursing reviewed and adjusted the medication administration policy by shifting the prescribed morning administration time from 8 am to 9 am. This change provides staff nurses with a one-hour window before and after to complete timely administration. The adjustment has been confirmed with both the pharmacist and GP to ensure alignment with best practices.

An audit system has been implemented to monitor adherence to this two-hour window, and all staff nurses participated in a meeting and debrief, which emphasized the importance of following the updated schedule. Completed on November 8, 2024, with ongoing monitoring.

• Schedules have been implemented and posted in all units to ensure daily checks confirm that no opened single-use dressings are left in treatment rooms. A meeting with nurses on November 5, 2024, reinforced the importance of proper disposal practices to prevent cross-contamination. Senior staff conduct daily walkarounds to ensure adherence to these protocols and uphold high standards of infection control. Completed November 5, 2024, with ongoing daily monitoring.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

• A comprehensive review of restraints has been conducted to ensure alignment with best practices for individualized care. Each resident's care plan now includes detailed records of any alternative, less restrictive interventions considered before implementing restraints, such as bed rails. This information is also reflected in updated corresponding risk assessments, providing a clear documentation trail that prioritizes resident safety and autonomy in decision-making. Staff meetings held on October 10, 2024, and November 14, 2024, emphasized these updates and reinforced the commitment to prioritizing less restrictive options in resident care. This review was completed on November 14, 2024, with ongoing monitoring in place.

• The Director of Nursing is conducting an active audit of all care plans and assessments, with 45% completed to date and a goal of full completion by November 30, 2024. This audit ensures that each care plan is updated with the most current information, removing any outdated or generic details. It includes recent input from physiotherapy and Tissue Viability Nurse reviews, as well as GP instructions, to support a truly personalized approach for each resident.

Staff meetings on October 10, 2024, and November 14, 2024, emphasized to all nursing staff the critical importance of promptly updating care plans following any significant changes, such as hospital transfers or specialist consultations. Full completion of the audit is expected by November 30, 2024.

Oversight of this process will be maintained through monthly care plan audits, supplemented by additional spot-check audits conducted by the Group Clinical Director to ensure thorough compliance and accuracy in care plan documentation.

• All pre-admission assessments and comprehensive assessments will now adhere strictly to established protocols, with the Director of Nursing or Person in Charge responsible for verifying the accuracy and relevance of information, communicating it to staff nurses upon admission, and documenting it thoroughly in each resident's care plan.

The DoN has also conducted a comprehensive review of antimicrobial infections within the nursing home, confirming that care plans and related documentation are current as of October 21, 2024. To maintain these standards, monthly audits will be conducted.

• In addition, following a meeting on October 31, 2024, with the Infection Prevention and Control (IPC) Link person from the hospital, plans were established to implement additional audits and targeted training sessions (date to be confirmed) to further enhance nurses' knowledge and skills in infection prevention and control practices. This

initiative was completed as of October 31, 2024, with ongoing monitoring and training to ensure sustained compliance and high standards.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:

• A full review of restraints has been completed to ensure compliance with best practices in individualized care. Each care plan now includes detailed documentation of any alternative, less restrictive measures trialed before implementing equipment like bed rails. These details are also included in the corresponding risk assessments, providing a thorough record of the decision-making process to prioritize resident safety and autonomy. Staff meetings were held on October 10, 2024, and November 14, 2024, to discuss these updates and reinforce the commitment to less restrictive care options. Completed 14/11/24 and ongoing monitoring.

• The Director of Nursing has conducted a thorough review of care plans and assessments for residents exhibiting responsive behaviors. To address the identified gaps, the DoN is actively monitoring incidents to ensure that all follow-up actions are implemented and that documentation, including the ABC charts, is completed comprehensively for each resident displaying such behaviors.

Additionally, all care plans have been reviewed to identify potential triggers and implement supportive interventions aimed at preventing responsive behavior episodes, ensuring a proactive and individualized approach to resident care.

Debriefing sessions and staff meetings were held on November 5, 2024, and November 14, 2024, to reeducate staff and reinforce the importance of complete and accurate documentation in supporting individualized behavioral care plans. These sessions emphasized the critical role of thorough documentation, particularly with the ABC charts, and focused on identifying triggers and implementing effective interventions to proactively manage responsive behaviors. This approach aims to ensure that each resident receives tailored care that addresses their unique needs and promotes a supportive environment.

To ensure ongoing compliance, both the Group Clinical Director and DoN will conduct frequent audits of this practice. Completed 14/11/24 and ongoing monitoring.

• All residents who smoke have been added to the Restraint Register. Each has an appropriate assessment in place, and their care plans have been updated with clear instructions to ensure their safety and well-being. Completed 21/10/24.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	23/10/2024
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	23/10/2024
Regulation 23(c)	The registered provider shall ensure that	Not Compliant	Orange	13/12/2024

	management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 29(5)	The person in charge shall ensure that all 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.	Not Compliant	Orange	13/12/2024
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	25/10/2024
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	Not Compliant	Orange	30/11/2024

	immediately before or on the person's admission to a designated centre.			
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.	Not Compliant	Orange	14/11/2024