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:	13 March 2023
Centre ID:	OSV-0000182
Fieldwork ID:	MON-0039362

About the designated centre

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

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	89

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 13 March 2023	16:05hrs to 22:20hrs	Helena Budzicz	Lead
Monday 13 March 2023	16:05hrs to 22:20hrs	Brid McGoldrick	Support

What residents told us and what inspectors observed

Overall, inspectors found that staff were working to improve the quality of life in the centre. This evening inspection took place in Talbot Lodge Nursing Home over the course of a day between 16:05hrs and 22:20hrs. There were 89 residents residing in the centre, with 14 vacancies on the day of inspection.

An opening meeting was held with the Clinical Nurse Manager 2 (CNM 2) as there was no person in charge appointed in the centre on the day of the inspection. Following a brief introductory meeting, inspectors commenced a walkabout of the premises. This gave inspectors the opportunity to meet with residents and staff, observe and hear about the lived experience of residents in their home environment and observe staff practices and interactions.

Staff were observed to be busy, rushing to attend to residents' requests for assistance with their evening care needs. Residents appeared to be well-dressed and were neat and tidy in their appearance. Inspectors spoke with individual residents and also spent time in communal areas, observing residents and staff interactions. The staff in the centre appeared familiar with the residents and were attentive towards them. However, inspectors also observed instances of staff interactions with residents which were not person-centred and that the residents were not always assisted with their needs in a discreet and dignified manner.

Residents' bedrooms were observed to be clean and tidy; however, some of the furniture, such as bedside tables and the vanity stand in the bathrooms, were seen to be rusty and damaged, specifically in the Estuary B unit. Most of the residents' bedrooms were personalised with items they had brought in from home. However, inspectors also observed that some of the emergency call chords were not available in a number of the residents' bedrooms. Additionally, some mattresses and other supportive equipment were damaged and not cleaned to an appropriate standard, thus increasing the risks of cross contamination.

There were a number of living rooms and dining areas where residents took their meals, spent time and participated in activities. Inspectors observed staff chatting and playing ball games with the residents in one of the units. However, inspectors saw that the environment in the communal dining areas was in need of attention to ensure it was maintained and cleaned to a good standard.

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

Capacity and capability

Overall, this inspection found that the management and oversight of this service were not effective, and the quality assurance processes in place did not ensure that this service was safe, appropriate and met the needs of the residents. While inspectors acknowledge that the compliance plan dates set out by the provider had not been completed yet, there had been very little progress in respect of addressing the previously identified issues arising from the last inspection of 11 January 2023. Significant action was required to bring the centre into compliance with the care and welfare regulations and to appoint a Person in charge of the centre.

There had been a number of unsolicited information of concern received prior to this inspection by the Chief Inspector of Social Services in respect of standards of care planning, safeguarding, residents' rights, staffing levels and governance and management. These concerns were substantiated during this inspection, and the inspectors' findings are discussed under the relevant regulations in this report.

Talbot Lodge nursing home is operated by Knegare Nursing Home Holdings Limited and is registered to accommodate 103 residents. Talbot Lodge nursing home is part of Brookhaven Healthcare Group, which operates a number of other nursing homes throughout the country. The governance structure comprised a board of directors with the Chief executive officer (CEO) appointed as the nominated person representing the registered provider.

The management structure operating the day-to-day running of the centre consisted of Clinical Nurse Manager 2 (CNM 2), who was supported by three clinical nurse managers, a team of registered nurses and health care assistants, activity, catering, housekeeping, laundry, and maintenance staff. The provider's Statement of Purpose (SOP), which was aligned with its registration condition, outlined that the centre should operate with a Person in Charge, an Assistant Director of Nursing (ADON) and four Clinical nurse managers (CNMs) as part of the centre's management structure. There was no Person in Charge (PIC) in the centre, and the Assistant Director of Nursing (ADON) was appointed on the day of the inspection. The Clinical Nurse Managers were working as staff nurses to compensate for staff shortages and were not supernumerary at the time of inspection.

While it was evident that the management staff working in the centre were working hard to monitor the service, the depleted management structures adversely impacted the quality and safety of the service provided and resulted in inadequate staff supervision and clinical oversight. Furthermore, the lines of authority and accountability were not identified within the current structure.

Inspectors were informed that six residents had been admitted to the centre since the last inspection. Following the inspection and subsequent engagement with the Office of the Chief Inspector in the form of a cautionary provider meeting, the provider had voluntarily taken a cautious approach to stop admissions to the centre until the new management structure was established. The provider is committed to strengthen the governance arrangements and management structure of the centre and take all necessary actions to comply with the regulations.

Inspectors were informed that there was an ongoing training schedule in place. However, there were gaps in knowledge among staff who spoke with inspectors with regard to the management of fire incidents and evacuation and safeguarding incidents. Additional detail is provided under Regulation 16: Training and staff development.

Regulation 14: Persons in charge

There was no person in charge of a designated centre.

Judgment: Not compliant

Regulation 15: Staffing

Inspectors found that on the day of the inspection, staffing levels were not sufficient to meet the needs of residents. This was evidenced by inspectors observing the following:

- Castle and Seaburry unit: There was one staff nurse allocated to work between the two units, which was required to take on additional responsibilities, such as supervising residents in communal areas. These arrangements did not provide assurance that residents could be monitored effectively.
- Clinical Nurse Managers were working as staff nurses during the week to compensate for staff shortages and did not provide the managerial oversight and supervision to monitor the service effectively. The CNMs, as part of the management team, were working in silos, with the allocated supernumerary time at the weekend spent only on the unit they were assigned to, and therefore not taking responsibility for the service.
- There was no Assistant Director of Nursing employed in the centre.
- There was insufficient cleaning and inadequate allocation of the household staff. The cleaning staff completed their shift at 16.30hrs. Inspectors observed unclean premises such as communal rooms, dining rooms and communal bathrooms. Inspectors were informed that the night care staff would clean the communal areas. This arrangement reduced the number of hours available for the direct care of residents.

Judgment: Not compliant

Regulation 16: Training and staff development

While staff had attended training according to their roles and responsibilities, they did not have sufficient knowledge and therefore did not implement the principles of their training in practice. Increased supervision and additional training in the evacuation procedure and management of fire and safeguarding incidents were required to facilitate their application of knowledge into practice.

Inspectors observed instances where the staff members working in the centre did not sufficiently support residents living with dementia or other conditions which required assurances, re-orientation and gentle navigation.

Inspectors observed that staff members working in the centre were not aware of the Act and any regulations made under it, and any relevant standards set and published by the Authority. Copies were not available to staff working in the centre.

Judgment: Not compliant

Regulation 23: Governance and management

The centre did not have sufficient resources in place to ensure the effective care delivery of care in accordance with its Statement of Purpose (SOP).

- There was not a clearly defined management structure that identified the lines of authority and accountability, specifying roles and responsibilities for all areas of care provision since December 2022.
- There was no person in charge of the centre. The overall responsibility for the centre's day-to-day run rested with the clinical nurse manager, who worked Monday till Friday and was on call during the night. These arrangements did not ensure that the service provided was safe, appropriate, consistent and effectively monitored, as evidenced by relevant regulations in this report.
- There was an absence of managerial and clinical oversight, with clinical nurse managers filling in for staffing shortages and, therefore not fulfilling their supervisory roles
- The management and oversight of the daily allocation of nursing resources did not ensure that residents were provided with the nursing care and supervision that they needed. For example, residents' dependency levels were used to inform staffing requirements, yet the inspectors found that the dependency assessments were not carried out in a timely manner and were not used to meaningfully inform the allocation of resources.
- Management systems in place did not ensure that the service provided was safe, consistent and effectively monitored. Inspectors found several risks that had not been identified and managed to ensure residents' safety and well-being. For example, risks associated with deficits in staff knowledge in respect of the evacuation of the residents in the event of a fire, or with the fire evacuation procedure which nominated the role of coordinator of fire

response at night time, which was not implemented in practice.

Judgment: Not compliant

Quality and safety

Overall, the poor governance and management structures and systems described in the Capacity and capability section of this report did not fully support the provision of person-centred, high-quality and safe care to the residents in a clean and safe environment that met their individual and collective needs. Significant improvements were required in key areas of quality and safety, such as premises, fire safety, care planning, infection prevention and control and residents' rights to ensure residents' safety was promoted and maintained at all times.

A selection of care plans and validated nursing assessments were reviewed by inspectors. The provider had a system in place to complete a pre-admission assessment for all residents. A review of pre-admission assessments completed for a sample of residents found that they were not documented and completed within 48 hours following the admission and were not sufficiently detailed to appraise whether the centre would have the resources and capacity to meet the needs of the residents. For example, the dependency level of a resident was not identified and used to plan resources required for the care of the resident.

The provider had taken action to improve infection prevention and control measures in the centre since the previous inspection. This included the deep cleaning of the facilities in the centre. However, there were areas of the premises and residents' equipment that were still visibly unclean. Additionally, staff did not have access to an Infection Control specialist as recommended by the standards. This is further discussed under Regulation 27: Infection control.

Inspectors acknowledge that there was ongoing work on the premises and that some findings from the previous inspection had been completed. Nevertheless, there were other aspects identified in respect of premises that required review to ensure that the premises conformed to the matters set out in Schedule 6 of the regulations. These are further outlined under Regulation 17: Premises.

Inspectors found that the arrangements in place to ensure the containment of fire in the event of an emergency were not adequate. There was a significant distance to travel from the fire alarm panels to some areas of the building, which may lead to delayed response times when the fire alarm is activated. Further findings from this inspection found that fire safety review and action were required to ensure full compliance with Regulation 28: Fire precautions.

Inspectors observed an unacceptable institutional approach to care and found that interactions by some staff with residents were predominantly limited to providing care interventions with no evidence of quality dementia-orientated rights-based

interactions as discussed under Regulation 9: Residents' rights.

Regulation 17: Premises

While a plan of renovations works was in place in respect of premises and environment, the following issues also required action to ensure the premises were well-maintained:

- The grabrails were missing in the residents' communal toilet facilities in the Estuary C unit.
- There was no emergency call-bell in the sitting room in the Seabury unit. The emergency-call chords were not available in each of the residents' bedrooms.
- The doors on the Storage/Comms room were not closing and posed an ongoing health and safety risk to residents- this was a recurrent finding from the previous inspection.
- There were exposed or broken sockets in the store room of the Estuary B unit and in the corridor. A cracked toilet cover, identified on the last inspection, had not been replaced. Inspectors observed that the crack had been sealed, but additional breaks were found at the back of the cover. This did not support effective cleaning and prevent the risk of cross infection.

Judgment: Substantially compliant

Regulation 27: Infection control

The inspectors found that the registered provider had not ensured that some procedures were consistent with the National Standards for infection prevention and control in community services (2018). This presented a risk of cross-infection in the centre. A number of these were repeat findings from the previous inspection. For example;

- Some surfaces, such as shower bases, toilets, high chairs for toilets, arm chairs, flooring and furniture, were worn, rusty and poorly maintained and did not facilitate effective cleaning.
- The management of residents' equipment was not appropriate. Wheelchairs, showers and arm chairs were unclean or not cleaned to appropriate standards.
- There was inappropriate and misuse of personal protective equipment (PPE). Staff were observed wearing gloves while assisting residents with random activities and wearing gloves in corridors.
- Inspectors noted loose clean incontinence wear stored in many places, including on the laundry trolley and in store rooms.
- A sample of mattress covers viewed was torn and worn and required

replacement, as they were no longer fit for purpose and posed a risk of contamination.
- The cleaners' room for the kitchenette in the Seaburry unit was not clean, with dirty buckets and inappropriate storage observed in this area.
- Vacant rooms were not cleaned effectively, in line with the terminal cleaning process outlined in local policy.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider was failing to meet the regulatory requirements on fire precautions in the centre and had not ensured that residents were protected from the risk of fire. Day-to-day arrangements in place in the centre did not provide adequate precautions against the risk of fire. For example:

- Inspectors observed gaps between the fire doors, damaged doors, and some doors were not closing correctly.
- Fire exits and fire doors were blocked by chairs and trolleys.
- Internally some signage and emergency lighting were missing to indicate the route to access a fire exit. In the event of an emergency, this could cause confusion and could delay an evacuation. Externally, emergency lighting was missing along some fire exit routes and above fire exits to illuminate the route of escape in the event of a fire evacuation at night time, and this required a review by the provider.
- Some of the fire exits had blinds which covered the safety signs. This posed a risk that signage would not be visible to support evacuation.
- The fire panel and the repeated panel did not display the correct time.
- The location of the communications equipment may pose a fire risk as it was located in the nurse station, which was open to the bedroom corridor. The location of the Comms equipment required to be risk assessed and to determine a suitable location.

The provider needs to improve the maintenance of the building fabric and the means of escape. For example, the inspectors were not assured of the ability of a selection of fire doors to prevent the spread of smoke and fire. Gaps were noted at the bottom and between doors. Furthermore, a number of fire doors were damaged and did not close fully when released. These deficiencies posed a significant risk to residents in the event of a fire.

Inspectors acknowledge that some fireworks had been completed since the previous inspection. However, several areas in the centre were noted to have utility pipes or cabling that penetrated through the fire-rated walls and ceilings and required appropriate fire-sealing measures. There were a number of ceiling hatches for which confirmation was required that these were fire rated. The communications

equipment in the Estuary C unit required review as it was not fire protected.

The procedures for the evacuation and safe placement of residents in a fire emergency in a timely manner with the staff and equipment resources available required attention. While fire evacuation drills were taking place, further fire drill practice was required in order to further support staff to protect residents from the risk of fire. Staff were not knowledgeable about the location of compartment boundaries. In addition, assurances were required as to the ability of staff to safely evacuate residents from the largest compartment using the lowest staffing levels and taking account of resident dependencies. The procedures displayed were not accurate as they made reference to a night co-ordinator for which there was no such role currently in the centre.

The display of procedures in the centre required improvement as they did not accurately:

- Reflect on the location of fire extinguishers.
- There was an insufficient number of plans displayed throughout all units.

Assurance was required in respect of compartment boundaries, for example, for room 41 and also the dining room opening on to corridor close to bedrooms 27 and 28. In addition, further assurance was required regarding procedures for the safe evacuation of residents in room 23, as there was no key available at the exit door from this room.

Given the totality of the risks identified, a full fire risk assessment by a competent person should be carried out, and the report should be used to develop a time-bound action plan to address the risks identified.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

- Inspectors were not assured that all newly admitted residents to the centre were comprehensively assessed and had appropriate care plans created no later than 48 hours after the resident's admission.
- Inspectors saw examples where wound care plans had not been updated with appropriate treatment instructions as recommended by the health care specialist professional since April 2022. This posed a risk that the resident was not receiving care in line with the care plan.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Inspectors were not assured that residents' choices and preferences were always respected and prioritised. For example, during the course of this inspection, inspectors observed how a resident's valid request for a change of rooms was repeatedly dismissed by staff. There was no effort made to facilitate this wish or provide the resident with a rationale for refusal. As a result, this lack of reassurance or inappropriate communication with the resident caused the resident to be more upset.

On other occasions, inspectors observed staff inadequately supporting confused residents living with dementia and not informing them about their intended care tasks or re-orienting residents adequately. As a result, these actions did not uphold residents' rights to determine how and where they spent their day.

Additionally, these practices were not person-centred, which limited residents' opportunities to choose and engage in meaningful social interactions with each other and with staff.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Talbot Lodge Nursing Home OSV-0000182

Inspection ID: MON-0039362

Date of inspection: 13/03/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: A Senior Member of the Brookhaven Clinical Support Team was appointed as the incumbent Person in Charge from 06.04.23, and the newly appointed Person in Charge commenced on 02.05.23. An ADoN has also been appointed and has commenced their post.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: (i) To support and ensure effective staffing levels, oversight, and recruitment, since the inspection the following positions have been filled Group HR Manager, Compliance & Quality Manager and Regional Manager x 2 (one of which is a temporary appointment). (ii) There continues to be an active and ongoing recruitment process and to date an Assistant Director of Nursing has been appointed; there are 2.5 WTE Clinical Nurse Manager posts, with additional posts currently advertised to ensure that the staffing levels meet those outlined in the Statement of purpose. (iii) The CNM who is rostered to work weekends, now takes responsibility for the management of the centre, and has access to the Person in Charge / Assistant Director of Nursing, who provide out of hours/ on call support. (iv) 4 Registered Nurses have been recruited. 3 have completed induction. A nurse continues to be allocated to each unit for the day and night shift, which supports supervision and effective monitoring of residents and junior staff. (v) 10 Health Care Assistants have been appointed and have completed induction, and recruitment is ongoing.	

(vi) a full time Administrator and a further 0.5 WTE maintenance person have been appointed (this is in addition to an existing 1 WTE maintenance person).
(vii) There is a full time House Keeping Manager in the centre, a new cleaning schedule and ''checking" system is place. The House Keeping roster is currently under review, with the intent of revising the House Keeping working hours beyond 4:30pm.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Regulation 16 (1)(b):
(i) Fire safety & safe evacuation training has been booked for all staff May through to July 2023. Fire drills will be completed fortnightly for the next two months, and then monthly thereafter.
(ii) An external service provider has been arranged to provide in-house Safeguarding training for all staff, dates booked for April & May with further dates to be arranged.
(iii) The Director of Nursing will complete a series of QUIS audits, to identify communication training needs, and arrange appropriate training to address identified issues.

As part of the quality improvement program regular QUIS observations will be included.

Regulation 16(1)(c); Regulation 16 (2)(a); Regulation 16 (2) b: Copies of the Health Act and relevant statutory Instruments, regulations, HIQA Standards, and other relevant guidance documents will be available within the centre, and staff will be informed of this. This Person in Charge will discuss the above documents with the Nursing Home clinical management team, to ensure that they have improved understanding and knowledge of the Act and regulations.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Regulation 23 (a)(i) A Senior Member of the Brookhaven Clinical Support Team was

appointed as the incumbent Person in Charge from 06.04.23, and the newly appointed Person in Charge commenced on 02.05.23.
(ii) To support and ensure effective staffing levels, oversight, and recruitment, since the inspection the following positions have been filled
(1) Group HR Manager (2) Compliance & Quality Manager (3) Regional Manager x 2 (one of which is a temporary position).
(iii) There continues to be an active and ongoing recruitment process. To date an Assistant Director of Nursing has been appointed. Currently there are 2.5 WTE Clinical Nurse Manager posts, with additional posts currently advertised to ensure that the staffing levels meet those outlined in the Statement of Purpose.
Of the CNM hours currently in place, 48 of these will be supernumerary to support supervision of staff and to meet the assessed needs of the residents.

Regulation 23 (b)There is a clearly defined management structure, with clear lines of authority and accountability.
(i) The are currently 2.5 WTE CNM in post, with ongoing recruitment. CNMs will be allocated 48 supernumerary hours weekly, to support their supervisory role.
(ii) A CNM is rostered to work weekends, this is in a supernumerary capacity. The CNM will have oversight and responsibility for all the units when on duty. The CNM supported by the Person in Charge/ Assistant Director of Nursing who will provide out of hours/ on call support.
(iii) Resident dependency levels will be assessed on admission, a minimum of 4 monthly and where there is a change in their status/ care needs. The Director of Nursing will ensure that this data is up to date and is used to support and inform the roster and allocation of staffing resources. Resident care needs and staffing allocation will be discussed at the Senior Management Governance Meetings.

Regulation 23(c) The Senior Management Team are currently reviewing all systems and processes within the home, this will include but is not limited to:
- Risk management and maintenance of the risk register,
- Assessing staffs' knowledge and understanding of training,
- Audits, oversight and monitoring,
- Health & safety and staff responsibilities

The management team will put in place robust systems to ensure effective care and delivery of care based on the assessed needs of the residents living in the centre. These systems will be overseen by the DoN and reviewed by the Regional Manager to ensure that any learning noted and identified has a positive effect on the day to day lived experiences of residents.

Regulation 17: Premises	Substantially Compliant

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

Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
(i) Grab rails have been replaced in Estuary C
(ii) Upgrades to Estuary C unit complete. A further audit of other units (which included communal areas and bedrooms) has been completed, a new call bell system is to be installed for Seabury unit by 30.06.23 and repairs to the other two units (Estuary B & Castle) to be completed by 31.07.23
(iii) Door to the storage and communications rooms have been fitted with keypad locks
(iv) Exposed/ broken sockets have been repaired within the identified areas of the centre.
(v) The cracked toilet seat has been replaced.
(vi) A monthly Health & Safety building ''walkthrough" which will include checking for the above issues, will be implemented, to be overseen by the DoN and accompanied by local maintenance, the household supervisor and another senior member of the local clinical management team (ADoN or CNM)

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
(i) An audit of chairs and seating is complete, and any items identified as not fit for purpose have been removed/replaced. An audit of all mattresses has also been completed and a refurbishment/replacement plan is being put in place. Shower trays and resident equipment have been deep cleaned and this will continue on an ongoing basis.
(ii) Cleaning programs and schedules will be put in place for wheelchairs, armchairs & shower chairs – to be in place by 30.06.23.
(iii) Training on infection control practices is ongoing and the CNM, Nurse & Team Leads will take responsibility for daily monitoring of use of PPE, to ensure that it is appropriate and in line with best practice guidelines.
(iv) A review of storage within the centre has been completed. Appropriate storage areas within the nursing home have been identified within each unit. The laundry management has been reviewed and a new system will be implemented by 30.06.23.
(v) The Chef will ensure that the catering cleaning room is kept clean, tidy and no inappropriate items are stored.
(vi) The House Keeping supervisor will ensure that all vacant rooms are cleaned and checked in the monthly Health & Safety walkthrough.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Regulation 28 (1)(a) An external Fire consultant has completed a full fire risk assessment which included a separate fire door audit. The findings of this report noted that the risk level of the centre was "Tolerable" and that "no major additional controls required". A meeting was held with members of the Board of Management on 02.05.23 and plans are now being put in place to address the identified action items and remedial works as part of the capital improvement plan for the centre. Fire related action items completed to date include: - Repairs and alterations to emergency lighting - Repairs to fire hydrants following annual inspections - 2 additional fire points have been established - A number of automatic door closers have been fitted around the home - Recommended changes to operating procedures and checklists relating to electrical appliances, smoking areas, cooking, storage and training are currently being implemented - The external oxygen storage cage has been relocated Fire related action to be completed include: - Fire plans / display of procedures and some policy documents are under review by an external consultant – expected to be in place by 30.06.23 - New fire doors are on order for the entry to the Seabury unit from reception and are expected to be installed by 30.06.23 - The fire risk assessment noted issues with doors – these issues require repairs as opposed to replacement. Currently awaiting external contractors to visit the nursing home to quote for these works, these works will then be scheduled based on the availability of contractors - The fire risk assessment also noted issues relating to penetrations in fire rated ceilings relating to utility pipes, vents / ducts and light installations. Currently awaiting external contractors to visit the nursing home to quote for these works, these works will then be scheduled based on the availability of contractors Regulation 28(1)(c)(i) & Regulation 28 (1)(e) Night coordinator – A nurse on night duty will be allocated to be the appointed Fire Coordinator for the night shift. The staff member allocated to check the daily ''means of escape' and fire panel visual check will also check, to ensure that where exit keys are used, these are in place. Regulation 28(1)(d) Fire safety & safe evacuation training has been booked for all staff May through to July, fire drills will be completed fortnightly for the next two months, and then monthly thereafter. All residents have a Personal Emergency Evacuation Plan in place which is readily available to staff.	

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Regulation 5(1) An admission checklist is in place and the Assistant Director of Nursing/ Clinical Nurse Manager will ensure that this has been completed and care plans for identified residents' assessed needs are developed within 48 hours. The audit schedule will include assessing the quality and completion of 'new admission' documentation. Any deficits noted will be used as training for staff nurses and will be re-evaluated by the CNM and ADoN to ensure their appropriate completion.

Regulation 5 (3) The Assistant Director of Nursing/ Clinical Nurse Manager will oversee wound care and ensure that all care plans are updated to reflect recommendations by specialist practitioners. All current wound documentation will be audited monthly as part of the tissue viability audit.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Regulation 9(3)(a): Resident committee meetings will be held monthly, and residents will have an opportunity to make suggestions at this forum. In addition the Director of Nursing will ensure that all requests from residents are listened to and actioned far as is reasonably practicable.

Regulation 9(3)(d): The Director of Nursing will complete a series of QUIS audits, to identify communication training needs, and arrange appropriate training to address any identified issues.
As part of the quality improvement program regular QUIS audits will be included to monitor the quality of staff interactions with residents. Post review of the QUiS findings, training will be provided as required.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 14(1)	There shall be a person in charge of a designated centre.	Not Compliant	Orange	02/05/2023
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	16/05/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	16/06/2023
Regulation 16(1)(c)	The person in charge shall ensure that staff are informed of the Act and any regulations made under it.	Not Compliant	Orange	12/05/2023
Regulation 16(2)(a)	The person in charge shall	Not Compliant	Orange	12/05/2023

	ensure that copies of the Act and any regulations made under it are available to staff.			
Regulation 16(2)(b)	The person in charge shall ensure that copies of any relevant standards set and published by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act are available to staff.	Not Compliant	Orange	12/05/2023
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.	Substantially Compliant	Yellow	31/07/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	08/05/2023
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and	Not Compliant	Orange	08/05/2023

	accountability, specifies roles, and details responsibilities for all areas of care provision.			
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	30/06/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	30/06/2023
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	28/02/2024
Regulation 28(1)(c)(i)	The registered provider shall make adequate	Not Compliant	Orange	28/02/2024

	arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.			
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Not Compliant	Orange	26/07/2023
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be	Not Compliant	Orange	01/05/2023

	followed in the case of fire.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	08/05/2023
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	31/05/2023
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	17/04/2023
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre	Not Compliant	Orange	31/05/2023

	concerned.			