Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Talbot Lodge Nursing Home
Name of provider:	Knegare Nursing Home Holdings Ltd
Address of centre:	17 Kinsealy Lane, Malahide, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	14 January 2026
Centre ID:	OSV-0000182
Fieldwork ID:	MON-0049086

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. 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:	58

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 14 January 2026	07:00hrs to 16:30hrs	Sheila McKevitt	Lead
Wednesday 14 January 2026	07:00hrs to 16:30hrs	Manuela Cristea	Support

What residents told us and what inspectors observed

Residents living in Talbot Lodge Nursing Home told inspectors that over the last three months the quality of care provided to them had improved. The inspectors spoke with approximately 18 residents and eight visitors about life in the centre. Residents said that things continued to improve, in particular the staffing levels during the day but also the quality and standard of care being delivered.

Residents stated that the improvements they had observed related to a reduction in waiting times in the mornings for their care needs to be met. One relative said they were unsure about how long the stability would last, however acknowledged that things had definitely improved. They said they had seen improvements before and it had all fallen apart just as quick. Another visitor said that they were worn out of hearing and being told “well, that happened before I was employed here” and that they seemed to be constantly dealing with a new person in management.

Inspectors were informed that two of the five managers commenced in their role the week prior to the inspection and were familiarising themselves with their roles and responsibilities. Residents knew the new person in charge and spoke positively about this person and all the new staff. It was mentioned a number of times to inspectors that there had been a lot of change in the staff over the past year. However, there was a higher focus on the standard of care being delivered and staff were not as rushed as they used to be. Inspectors followed up on this information and were informed that 65 staff had left and 59 joined the company since 01 January 2025, with 20 of these having left and a further 20 joining since the last inspection in early September 2025.

Inspectors arrived at the centre early in the morning and observed that in one of the units there was only one nurse providing care for 11 residents of various dependency levels. Inspectors were informed that a healthcare assistant from a neighbouring unit had assisted this nurse by attending the unit for an hour after midnight and again early in the morning. During that time, the resources in the unit where the healthcare asisstant was based were depleted to one nurse only. Such arrangements were not appropriate to provide safe effective care and oversight at night for all residents. Inspectors accepted the provider's assurances that a second healthcare assistant will be re-instated with immediate effect at night.

Inspectors observed breakfast and lunch being served to residents. The dining experience had significantly improved. There was a choice offered at each meal, assistance was available and the food was well-presented. All food was cooked in-house and inspectors observed a residents birthday being celebrated on the day of inspection with a home-made birthday cake. Feedback from residents about the food was mixed. At lunchtime some residents told inspectors that the food was “bland” and "not that good" while other residents said that ,the menu was varied, the food was served hot and there were always good quantities served on the plate.

One relative told inspectors that their loved one was now having their evening meal in the dining room which the resident enjoyed, in the past they had been served this meal in their bedroom.

Residents told inspectors that there was a schedule of activities and they were given a choice whether to attend activities or not. Inspectors saw residents participating in an exercise class, led out by a physiotherapist, which they appeared to be enjoying. One relative told inspectors that they would like to see residents being facilitated to go outside and enjoy the fresh air more frequently, such as a walk around the grounds. This was feedback to the management team at the end of the inspection.

The following sections of this report detail the findings with regard to the capacity and capability of the provider, and how this supports the quality and safety of the service provided to residents.

Capacity and capability

This unannounced risk inspection was carried out by inspectors of social services to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 to 2025 (as amended) and to review the provider's application to remove a condition of registration, which prohibited the admission of new residents to the centre.

The inspectors also followed up on a number of unsolicited concerns received since the last inspection in respect of staffing, care practices and clinical oversight and found that these concerns were either not substantiated or had been addressed, as further elaborated in the report.

Knegare Nursing Home Holdings Limited is the registered provider of Talbot Lodge Nursing Home. This service has been in escalation since July 2024, due to concerns about the care and welfare of residents and the failure of the registered provider to progress action plans in respect of premises and fire safety, which resulted in a restrictive condition being applied to the registration of the designated centre preventing admissions to two units. That condition remained in place however the restriction was changed to one unit only in November 2024, when inspectors found that the registered provider had implemented significant improvements. At that time, the inspectors were satisfied that this unit could reopen to admissions.

However, a subsequent inspection in April 2025 found that the provider was not compliant with the requirements of the restrictive condition attached to the registration. Following a warning meeting, the provider submitted an application to regularise their registration certificate, by varying their restrictive condition and committing to achieve all required fire safety works by 31st of July 2025. Subsequently, the Chief Inspector of Social Services issued a notice of proposed decision to renew the registration of the designated centre with an additional

restrictive condition. This condition required the provider to stop new admissions to the centre until the Chief Inspector was satisfied that the provider had in place an effective governance and management structure, and had achieved compliance with key regulations that underpinned the quality and safety of care provided to residents.

In response to the July 2025 notice of proposed decision, the registered provider made a representation detailing the action that had been taken by the provider: to address the non-compliance relating to the governance and management, and the quality and safety of the service through a revised organisational structure, to implement effective systems of management and oversight to monitor the quality and safety of care provided to residents. In September 2025, during an unannounced inspection, the inspectors found that these commitments had not been implemented, which resulted in the addition of two further restrictive conditions to the certificate of registration issued to the provider in October 2025. One in relation to a fire safety review and one which required the provider to stop all admissions to the centre. In December 2025, the provider submitted an application to remove the condition which prevented new admissions. The provider stated they had fully achieved and embedded the requirements of this condition and that robust systems were in place to ensure sustained compliance, effective governance and safe, person-centred care for all residents.

This inspection found that not all the requirements of the condition of registration had been met, as further outlined under Regulation 23: Governance and management. Inspectors found that the registered provider had put a management structure in place. It consisted of a person in charge, an assistant director of nursing and three clinical nurse managers. The assistant director of nursing and one of the clinical nurse managers were new to their posts since January 2025, the week prior to the inspection. Inspectors were informed that the provider planned to have five clinical nurse managers (CNMs) overseeing the service, with two of these posts vacant. On the day of inspection there was no CNM available to cover night duty, and therefore no management oversight at night, albeit a senior staff nurse working in one of the units was also nominated to be responsible for the whole centre. Although the provider had a CNM rostered on night duty in a supernumerary capacity one night per week this was not sufficient to meet the requirements of the restrictive condition or to provide the oversight required on night duty.

Inspectors met the new management team, two of whom had commenced in January 2026 and were still in the process of being inducted into their roles, the remaining three had commenced in quarter three of 2025. Two clinical nurse managers posts remained vacant, although inspectors were informed that these posts had been advertised. Inspectors found that the new management team were embedding themselves in their new roles and responsibilities, but needed time to do so. The full management team needed to be in place to ensure there was an adequate amount of oversight in place during the day and at night.

The systems for oversight had improved. Although in their infancy, new systems had been established and the implementation of these systems had been consistent for quarter four in 2025. This assured the inspectors that there was a greater oversight

of the service provided and this was reflected in the positive feedback received from both the residents and relatives. The quality and safety of the care provided to residents had improved. In addition, the standard of cleanliness had improved throughout the centre, particularly in the kitchenettes and dining rooms.

The accountability and responsibility for the oversight and monitoring of key aspects of the service was clear. Systems and processes for overseeing all areas of practice had been strengthened. This included improved oversight of the house-keeping staff, the catering staff and nursing care practices and had resulted in improvements in the standard of safe and quality care being delivered to the residents.

However, the staff turnover continued to be very high at all levels and across all disciplines. Since the last inspection of September 2025, 20 staff had left the organisation, including two in management roles, and 20 new staff had joined. In 2025, there was a turnover of almost 80% and inspectors were informed that 65 staff had left and 59 joined the company during that period.

This included one new CNM and the dementia nurse specialist who had moved into the role of assistant director of nursing, leaving the nurse specialist post vacant. Inspectors were informed that this formed part of a restructuring of the governance and management arrangements at the centre. Although staffing levels had improved during the day, there were not enough staff rostered to meet the needs of the residents in one of the units during the night, as further discussed under Regulation 15: Staffing.

The standard of nursing documentation and general record keeping had improved.

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

The provider submitted an application and supportive evidence to remove the restrictive condition number five in respect of restriction of admissions to the centre.

Judgment: Compliant

Regulation 15: Staffing

There was not a sufficient number of staff rostered on night duty to ensure that the care needs of the residents in one of the units were met in a timely manner and that there was adequate oversight of staff on this unit. Inspectors found the staffing levels did not take into account the lay out of the units. There was one staff nurse allocated to care for 11 residents on Castle Unit for a twelve hour period at night. While one staff from another unit provided assistance for approximately two hours during the night, it still left residents at risk. Inspectors found that two of the 11 residents living in Castle unit required the assistance of two staff while one resident

was assessed at risk of choking and of absconsion. The management team committed to putting a second staff member on this unit going forward.

The full proposed governance and management team was not in place.

Judgment: Not compliant

Regulation 16: Training and staff development

The level of supervision on day and night duty had improved, however it was not in line with the commitments made by the registered provider as set out in the restrictive condition. There was a senior staff nurse identified as the nurse in charge on the night roster. The director of nursing, assistant director of nursing and the clinical nurse managers were overseeing the care being provided on each unit during the day. However, there was no clinical nurse manager rostered on night duty to oversee practices and the covering senior staff nurse was not supernummerary and was the only staff nurse working in the unit she was allocated too. Hence, in the event of an emergency this unit would be left with just one member of healthcare assistant caring for them.

Judgment: Substantially compliant

Regulation 21: Records

The maintenance and management of records had improved and records required to be available for review were available and they reflected the care residents were receiving. This care was as per that prescribed in the residents care plan.

Judgment: Compliant

Regulation 23: Governance and management

Notwithstanding the improvements in governance and management arrangements, the inspectors found that the only requirement of the restrictive condition that had been fully met was in respect of premises and cleanliness. There was however progress made in respect of each of the following four areas that had been specifically identified in the restrictive condition, with some outstanding actions remaining as follows:

- The centre was not adequately resourced to meet the needs of the residents day and night as evidenced by insufficient staffing at night in one unit. The

organisational structure, as described in the centre's statement of purpose was in place, however this organisational structure was for 58 residents. The management team was not fully in place. There were three of five clinical nurse managers in place to date, none of which were assigned for oversight at night. Five clinical nurse managers were planned to be in place to ensure adequate resources for full occupancy of 103.

- While there was a governance structure in place, there was a lack of assurance that this structure was stable, as significant turnover impacted the service at all levels, including management. Some of the management team were new in posts and had not yet familiarised themselves with their roles and responsibilities.
- While improvements were evident in the care provided to the residents, there continued to be some gaps in respect of ensuring that residents assessed needs were reflected in their care plan, as detailed under Regulation 5.
- While referrals to specialist healthcare practitioners were completed in a timely manner, there was poor oversight to ensure that professionals recommendations were consistently implemented in practice as outlined under Regulation 6.

The management systems in place to ensure the service provided is safe, appropriate and consistently monitored had been strengthened since the last inspection, however improved oversight in some aspects of service continued to be required. For example:

- Senior management present on the day of inspection informed the inspector that they were not aware of the decision to reduce the night time staffing levels in the Castle unit, based on the reduced number of residents. The second healthcare assistant was reinstated with immediate effect on the evening of the inspection.
- Care planning audits identified some but not all areas for improvements. A medical model of care that focused on the clinical aspects only was evident in end-of-life care planning arrangements. A renewed focus on end-of-life care planning arrangements was required to ensure a holistic person-centred approach to care at the end of life, in line with regulatory requirements.

Judgment: Not compliant

Regulation 3: Statement of purpose

A revised statement of purpose was submitted on the 30 December 2025, in which the staffing levels had been adjusted and did not meet the statement of purpose linked to the certificate of registration. In addition, it did not match the proposed organisational structure outlined to inspectors on inspection.

Judgment: Substantially compliant

Quality and safety

Inspectors found that aspects of the quality and safety of care provided to residents had improved with the strengthened governance and management arrangements and oversight described under the Capacity and Capability section of this report. This inspection identified that the delivery of care had improved significantly particularly in the implementation of treatment recommended by allied professionals, but also in relation to the quality of the assessments and care plans in place. Nothwithstanding the improvements made, there were still gaps in these areas which required further review. In addition, the inspection found that the condition of the premises had improved particularly in Castle Unit where all work was now completed.

The improvements in the quality of the nursing documentation with regard to the residents' individual assessment and care plans was noted by both inspectors across all units. While there was evidence that residents' needs had been assessed using validated assessment tools, the care plans reviewed were not always fully informed by these assessments, and a small number did not reflect person-centred guidance on the current care needs of the residents. In addition, not all care plans were reviewed as the residents' condition changed or when recommendations were made. Some further opportunities for improvement were identified as further outlined in Regulation 5: Individual assessment and care plan.

Residents had good access to general practitioners (GP) and a range of healthcare professionals such as physiotherapists, occupational therapist, dietitians, tissue viability nurse and speech and language therapists and overall, there was evidence that residents were referred to these specialists when required. Despite the significant improvements in managing the health and care needs of the residents, there continued to be gaps in the provision of service which required further action to ensure the safety of the residents, as described in Regulation 6: Healthcare.

The refurbishment of Castle unit was complete. The centre was found to be clean and tidy and the oversight of the general house keeping in the centre had improved.

Regulation 17: Premises

The registered provider, having regard to the needs of the residents at the centre, had made the required improvements to the premises which assured inspectors that it now conformed to the matters set out in Schedule 6 of the regulations.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Notwithstanding the noted improvements in the overall standard of nursing documentation particularly nursing assessments and person-centred care plans, some gaps and discrepancies in nursing records were identified which had the potential to negatively impact the care being delivered to residents. For example:

- The monitoring interventions required for a resident assessed at high risk of absconsion and with active exit-seeking behaviours were not sufficiently person-centred and informed by an individualised assessment of risk. All residents presenting with this type of behaviour were on 30 minute safety checks. Even though in December 2025 there had been four incidents involving one particular resident, the care plan and associated intervention continued to be regular checks at 30 minute intervals.
- One resident with two bed-rails in use had a bed-rail risk assessment in place, but it was not clear in this assessment or from the resident's care plan what, if any, alternatives had been trialled and failed prior to restraints been used.
- A sample of end-of-life care plans reviewed were not holistic in the approach to end-of-life care. They guided staff on what to do if the resident became unwell, therefore staff were aware of key information in respect of clinical decisions such as resuscitation status in the event of a cardiac arrest, or transfer to hospital. However, the care plans did not reflect any information in relation to the residents' spiritual, religious or personal preferences at the time of death.
- In one instance, the handover of the nursing staff contained inaccurate information in respect of the resuscitation status of one resident. This posed a significant risk that the resident would not receive care in line with their wishes, and had been a finding of previous inspections.
- One resident identified as at risk of malnutrition had an incorrect score on their recent malnutrition assessment tool, the revised score indicated that the resident risk status had improved when in fact it had not, the residents weight had only increased by .2 kilograms between both assessments, this meant they were still at risk of malnutrition. This could potentially adversely impact the care of the resident.

Judgment: Substantially compliant

Regulation 6: Health care

Members of the multi-disciplinary team were accessible to residents. These visits were reflected in residents' individual records and recommendations made by team members were generally carried through in practice. However, inspectors noted that for one resident recommendations made by a healthcare professional who reviewed

this resident at regular intervals were not being implemented in practice. The management and nursing team were not aware of the agreed plan for this resident and there was no evidence of a risk assessment or a multi-disciplinary decision to inform the care being provided. For example: the frequency of safety checks on a resident who had been assessed as being at a very high risk of absconsion was at 30 minutes intervals, instead of the 15 minutes agreed with the relevant professional overseeing the case. Records showed that this recommendation had been repeatedly documented in resident's care notes and not implemented. This posed a safety risk that had not been fully mitigated and was similar to findings of previous inspections.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant

Compliance Plan for Talbot Lodge Nursing Home OSV-0000182

Inspection ID: MON-0049086

Date of inspection: 14/01/2026

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. An additional Care staff was added in the Castle unit immediately on the evening of the inspection to support the RGN for the 11 residents in this unit. 2. The updated staffing level was communicated to all staff in the different units. 3. A CNM will be rostered to a night-time supervisory role, seven nights per week, to provide clinical guidance and additional support as required. 4. A fourth CNM has been recruited and is due to commence employment on successful garda vetting.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: A review of night-time supervision arrangements has been undertaken in response to the findings. To address this, a Clinical Nurse Manager will be rostered in a supernumerary capacity over 7 nights per week to provide enhanced clinical oversight, leadership, and guidance to all staff across the units. This will ensure that: • There is consistent senior clinical supervision on night duty • Staff have immediate access to support and guidance	

• Safe and effective care delivery is maintained across all units
• Risks associated with staff redeployment during emergencies are mitigated

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 acknowledges the findings in relation to governance and management and has implemented the following measures to ensure the service is safe, appropriately resourced, effectively monitored and in line with the restrictive condition.

Additional care staff have been rostered to Castle Unit at night immediately on the evening of the inspection to ensure safe supervision, timely response and delivery of care. Staffing levels have been reviewed in line with resident dependency and the layout of the units and communicated to all staff.

A Clinical Nurse Manager will be rostered in a supernumerary capacity on night duty, 7 nights per week to provide clinical oversight, leadership, supervision and guidance to all staff across the units. This will ensure consistent management presence at night, support for staff, and safe decision-making in the event of an emergency. The Director of Nursing/Assistant Director of Nursing also remain on call to support staff out of hours.

The provider is progressing recruitment to ensure the full management structure is in place. A fourth CNM has been recruited and is due to commence employment subject to successful Garda vetting. Recruitment is ongoing to achieve the full complement of five CNMs in line with full occupancy of 103 residents. This will strengthen governance, oversight and accountability across the service.

Governance systems have been strengthened to ensure effective monitoring of the service. A system is in place whereby all multidisciplinary team recommendations are implemented on the day or within 24–48 hours, incorporated into residents' care plans and communicated at handover. CNMs will complete regular spot-checks to ensure that MDT recommendations are consistently implemented in practice.

Care plans have been reviewed and updated to ensure a holistic, person-centred approach to care. End-of-life care plans now incorporate residents' wishes and preferences.

Risk assessments have been completed and updated to ensure care delivery reflects residents' current needs and risk profiles.
Audit systems have been strengthened to improve oversight and consistency of care. Monthly and weekly audits are in place in relation to care planning, restrictive practice, nutrition, and clinical documentation. Findings from these audits are reviewed by the

management team and actions are implemented and monitored. Communication systems have been reinforced to ensure all changes in care, risks and interventions are clearly documented, communicated at handover and understood by staff. Handover sheets are regularly reviewed to ensure accuracy of information. These measures will ensure that the centre is appropriately resourced, that there is a clearly defined and stable management structure, and that effective governance and oversight systems are in place to ensure the service provided is safe, appropriate, consistent and effectively monitored.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The Statement of Purpose has been revised, updated to reflect the required changes, and submitted to the regulator.	
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: To improve compliance with regards to clinical documentation, risk assessment, person centred care planning, Restraint management, Nutrition, the following corrective actions have been implemented: 1. A comprehensive, individualised risk assessment has now been completed for all residents identified as being at high risk of absconsion and presenting with exit-seeking behaviours. Safety check intervals are no longer applied as a standardised approach. Instead, the frequency of monitoring interventions is now determined by the outcome of each resident’s individual risk assessment, ensuring a person-centred and responsive approach to care. Care plans have been updated accordingly to reflect: • Individual risk levels • Specific triggers and behaviours • Appropriate supervision and monitoring requirements These measures ensure that supervision is tailored to each resident’s needs and that risks are effectively managed.	

2. The centre's policy on restrictive practice has been reiterated to all staff by the Person in Charge and Assistant Director of Nursing, with emphasis on ensuring that all alternatives are considered, trialled, and documented prior to the implementation of any restrictive intervention.
Care plans and risk assessments are being reviewed and updated to clearly reflect:
• Alternatives trialled
• Outcomes of those interventions
• Clinical rationale for the use of bed rails, where applicable
In addition, a monthly audit will be completed by the ADON to monitor compliance with the restrictive practice policy and to ensure that best practice is consistently followed.

3. All residents, and/or their next of kin where appropriate, have been engaged with to obtain and document their personal, spiritual, religious, and cultural wishes in relation to end-of-life care. Where residents have indicated that they do not wish to discuss end-of-life preferences at this time, their wishes are respected. These residents will be sensitively re-approached at an appropriate later stage.
End-of-life care plans are being reviewed and updated to ensure they reflect a holistic, person-centred approach, incorporating:
• Spiritual and religious preferences
• Cultural and personal wishes
• Psychosocial needs

4. All resuscitation/DNAR status were verified to ensure the information is correct on the handover sheet. The handover sheet is cross checked by the CNMs monthly or as required if any changes to the residents condition. In addition, staff re-training on legal and ethical responsibilities with regards to clinical documentation is emphasized during safety huddles weekly to ensure communication accuracy.
5. All residents weight have been checked and their nutritional risk were re-assessed to identify any nutritional risk. Anyone with medium or high risk have been refered to a dietician, and MDT recommendations followed. A monthly audit is conducted by the CNM to verify all weights, and MUST to identify any potential risk. So, this dual system of verification will improve to identify any discrepancy and mitigate any risk timely.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The provider acknowledges the findings in relation to the failure to implement multidisciplinary team (MDT) recommendations, and the following corrective actions have been implemented:

1. The Person in Charge has reinstated the 15-minute safety checks for the particular resident referenced, as recommended by the MDT.
2. This change was communicated to all staff on the day of the inspection and reinforced

daily for one week. The updated intervention has been clearly documented in:
o The resident’s care plan
o Daily handover sheets
o Nursing progress notes
3. The resident’s safety plan, including the rationale for increased monitoring and risks associated with non-compliance, has been clearly communicated to the care team.
4. A comprehensive risk assessment has been completed, with clear control measures and actions identified to mitigate the risk of absconsion.
5. The resident’s care plan was fully reviewed and updated on 14th January to ensure that all MDT recommendations are accurately reflected and implemented in practice.
6. Compliance with the 15-minute safety checks is now being monitored weekly by the senior clinical team.
7. In addition, CNMs will complete regular spot-checks of MDT recommendations and associated care practices to ensure that all agreed interventions are implemented consistently and without delay.
8. A system has been reinforced whereby all MDT recommendations are:
o Clearly documented
o Communicated at handover
o Incorporated into care plans promptly

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	30/03/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	23/03/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/03/2026

Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Substantially Compliant	Yellow	23/01/2026
Regulation 23(1)(d)	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	30/03/2026
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	29/01/2026
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	14/02/2026
Regulation 6(2)(b)	The person in charge shall, in so	Substantially Compliant	Yellow	15/01/2026

	far as is reasonably practical, make available to a resident where the resident agrees to medical treatment recommended by the medical practitioner concerned, the recommended treatment.			