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:	24 April 2025
Centre ID:	OSV-0000182
Fieldwork ID:	MON-0046893

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:	84

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
Thursday 24 April 2025	08:00hrs to 18:10hrs	Sheila McKevitt	Lead
Thursday 24 April 2025	08:00hrs to 18:10hrs	Manuela Cristea	Support
Thursday 24 April 2025	08:00hrs to 18:10hrs	Maureen Kennedy	Support

What residents told us and what inspectors observed

Inspectors spoke with many residents and observed care practices throughout the day of the inspection. They spoke with residents about their experience of living in the centre. The feedback from residents was mixed. One resident who required assistance of two staff said that staff had come and told her that she had to wait until after lunch to get out of bed. In addition, in the Castle unit, staff reported to the inspectors that they could not transfer three residents out of bed that morning, as they required assistance of two people, which was not available, as the other staff were all busy. Other residents who spoke with the inspectors, gave positive feedback on the level of care they received.

Inspectors were told by a number of residents that there were not enough staff on duty to meet their needs. One resident described how they had attended resident meetings each month and the issue of insufficient staff was repeatedly brought up, but there was no change and no improvement. The resident explained how they had rang the call-bell and requested assistance with personal care and care staff had informed them that they would do so after they had served lunch to the residents.

The feedback from several residents was that their care needs were not being met in a timely manner due to a shortage of staff. Residents also explained to inspectors that it depended on what staff were on and how many as to how quickly their call-bell got answered. This was irrespective of whether it was day-time or night-time. Residents said that staff were overall kind, caring and respected their privacy, however there was not enough of them. Throughout the day, the inspectors observed that call-bells were unattended to for prolonged periods of time. In one particular instance in Castle unit, the call-bell rang for more than 15 minutes before staff attended to the call-bell.

Residents said they had a choice of two meals at meal times as per the menu displayed. However, some residents said that staff did not always ask them what they wanted to eat, some days they just got served a hot meal. A number of residents complained about the timing of the meals and the quality of the food. For example, they said the last hot meal was served at 16.30 hours which they felt was too early and that every evening, "365 days of the year" the choice was chips and some processed food or sandwiches. They also stated that, if staff were busy, they did not get offered drinks or snacks between meals. Due to an unplanned incident in one of the units on the day of inspection staff confirmed that some residents did not get offered this service between breakfast and lunch.

Inspectors observed there was a delay in the service of lunch in some of the dining rooms due to care staff being delayed providing direct care to residents. While some units had dedicated staff to plate up the meals, the care staff were responsible for serving and assisting the residents with their meals. Assistance was provided to residents once meals were served and this was consistent across all units.

Residents said they were supported to engage in activities that aligned with their interests and capabilities. Residents had access to local and national newspapers, televisions and radios in their bedrooms and in the communal areas. Information regarding advocacy services was displayed in the reception area.

Inspectors observed that the planned refurbishment of Castle Unit had not been completed by the end of October 2024 (the date set by the provider on the previous compliance plan), with just four single en-suite bedrooms having been refurbished since the last inspection.

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

Capacity and capability

This was an unannounced inspection in which inspectors observed that governance and management failures impacted the standard and quality of care provided to the residents living at the centre.

The standard of care delivered in this centre was not at an acceptable standard with failures found in relation to governance and management, staffing, premises, fire safety, care planning and the management of behaviours that challenge. The governance and management structure outlined in the statement of purpose was not in place and the registered provider did not have adequate oversight of the care of residents.

Talbot Lodge Nursing Home is operated by Knegare Nursing Home Holdings Limited and is registered to accommodate 103 residents, with 84 residents accommodated on the day of inspection. Previous poor compliance with regulations had resulted in the ceasing of admissions to Estuary C and Castle unit from May to October 2024. On foot of improvements implemented by the registered provider in October 2024 this condition was amended to open the Estuary C to admissions, with Castle unit to remain closed to admissions.

On five successive inspections in January, March, June and November 2023 and April 2024 the inspectors had found insufficient and ineffective governance and management systems and that the provider had failed to provide an adequate service. There was some improvement noted in July 2024, however this was not sustained and in October 2024 and again on this inspection, it was evident that the provider had not come into compliance with the regulations within the time-frames set by them. As a result of poor regulatory compliance, the Chief Inspector of Social Services had applied a restrictive condition to the certificate of registration which required the provider to complete fire related works by 31st of December 2024 and restricted admissions to the Castle unit. The findings of this inspection were that

while there was some progress in respect of fire related works, the requirements of the condition had not been met.

The provider was unable to maintain a stable management team and therefore unable to maintain effective management systems to ensure safe, appropriate, consistent and effectively monitored. This resulted in poor outcomes for residents.

For example, there was ineffective governance of the management and allocation of resources with leave granted without consideration to the impact on the oversight of the designated centre. Since the 7th of April 2025 a management team which comprised of five members (one director of nursing, one assistant director of nursing (ADON) and three clinical nurse managers (CNM)) was reduced to the ADON who worked full-time with the support on three days a week from a regional manager. The person in charge had returned from leave the day before the inspection, however there was still no CNM on duty.The impact of this was evidenced by complaints to the registered provider which highlighted issues in relation to poor staffing levels and poor standards of care. These issues were also referenced in concerns submitted to the Chief Inspector.

Further evidence of the registered provider's failure to appropriately manage this centre were evidenced by

- not meeting the requirements of the restrictive condition of the registration in respect of completing all fire-related works by 31st of December 2024.
- inadequate staffing levels to meet the needs of the residents in a timely manner.
- adhere to their commitment to renovate the Castle Unit

Inspectors found that there continued to be insufficient assurance mechanisms in place to ensure that the premises were refurbished to an acceptable standard. The provider's refurbishment plan was not adhered to, progress to date had been slow with only four rooms renovated to date, in which new residents had been admitted.

The inspectors noted that there were six open complaints made within the past two weeks, and upon review were satisfied that they were being dealt with as per the complaints policy.

Regulation 15: Staffing

There were insufficient numbers of staff on duty to meet the needs of residents. This was evidenced by the following:

- Call-bells were left unanswered for prolonged periods of time on the day of inspection; inspectors observed that it took 13 minutes to answer a call-bell in one of the units.

- A number of staff and residents spoken to at random during the inspection told inspectors there were not enough staff being rostered to meet the needs of residents.

The lack of appropriate staffing levels was having a negative impact on residents. For example:

- Three residents remained in bed; inspectors were told that the reason for this was that there were not enough staff to assist them to get out of bed.
- There was a delay in the service of lunch, due to care staff not being available to assist with service in a timely manner.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were not provided with the appropriate training to ensure they could meet the individual needs of each resident. For example, there was a high use of bed-rails as a physical restraint in the centre which had a negative impact on residents' rights with little evidence that alternatives had been trialled. Staff had not completed training in a human rights-based approach to care and only a small number had received training on restrictive practices.

In the absence of appropriate staffing levels and management structures, there was a lack of supervision of staff on each of the units.

Judgment: Substantially compliant

Regulation 21: Records

There were a number of gaps in the records of safety checks for residents identified at risk of absconsion, and inspectors were informed by staff that records were not being filled in contemporaneously. The inspectors also observed this practice.

The actual staff rosters did not reflect the staff on duty on the day of this inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

The designated centre did not have sufficient resources in place to ensure the effective delivery of care in a timely manner.

The governance structure described in the statement of purpose was not in place on the day of the inspection

- two of three clinical nurse manager (CNM) posts were vacant on the day of inspection. Inspectors were informed that these positions had been recruited into and one was due to commence in the coming weeks.
- in the weeks leading up to the inspection there was only one post-holder from the local management structure rostered as available in the centre, supported by a senior manager three days a week. In addition to vacancies above, two other post holders (person in charge and CNM) were on rostered leave. The registered provider did not ensure that sufficient resources were made available to support the management of the centre during these periods of leave.
- the registered provider did not ensure that there were adequate numbers of staff available to meet the needs of residents.

The systems of overseeing the care and service provided were ineffective at responding and addressing identified concerns:

- ongoing concerns raised by residents in respect of staffing and food during the course of the last four resident meetings were not addressed
- clinical oversight was not sufficient to ensure residents received a safe and high standard of quality care, care planning audits were ineffective at identifying areas for improvement and ensure that where actions were required they would be implemented by staff.

The registered provider was found to be operating in breach of its registration conditions as the required fire related works had not been fully completed by 31st of December 2024.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

There were contracts for the provision of service available for inspectors to view. They met the legislative requirements. The sample of contracts reviewed had been signed by the resident or their representative. The contracts included the fees to be charged, the room occupied by the resident and, where relevant, the number of occupants in the room.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a complaints policy in the centre and the complaints procedure was on display. The complaints policy and procedure identified the complaints officer and the person responsible for reviewing complaints. It also outlined the complaints process, how the outcome of the complaint should be communicated to the complainant, and it included contact details for an advocacy service.

The records of complaints reviewed assured the inspectors that all complaints were fully investigated in line with the policy. The records of the closed complaints included the outcome of the complaint investigation and the level of satisfaction of the complainant. There was evidence that all complaints were recorded.

Judgment: Compliant

Regulation 4: Written policies and procedures

Schedule 5 policies were available for review. Overall those reviewed reflected the practice in the centre and they had all been updated within the past three years.

Judgment: Compliant

Quality and safety

Inspectors found that the provider was not delivering a good standard of nursing care and the gaps in governance and management oversight, as mentioned in the Capacity and Capability section, impacted the quality of life for the residents living in the centre. The findings of this inspection are that further action was required in relation to assessments and care planning and managing behaviour that is challenging, premises and fire safety.

The sample of care plans reviewed by the inspectors indicated that the care provided to residents was not consistently person-centred and that their care needs were not always met. Residents' care needs were assessed using validated assessment tools as described in their individual care plans. Where risks were identified, the care plans described preventative measures to guide staff actions and prevent incidents or deterioration in health, however these care plans were not always adhered to by staff. Wounds and pressure area care were monitored on an ad-hoc basis and not in accordance with interventions informed by a specialist tissue

viability nurse. Where interventions had been prescribed by specialist practitioners, these were not always implemented by staff.

The National Transfer Document and Health Profile for Residential Care Facilities was used when residents were transferred to acute care. This document contained details of healthcare associated infections and colonisation to support sharing of and access to information within and between services. A copy of all resident transfer letters were kept on file.

There were policies, procedures and arrangements in place to manage risk and protect residents from harm. The centre maintained a risk register setting out hazards identified in the centre and the control measures in place to minimise associated risk.

The provider had put appropriate arrangements 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 safety policy. There were records evidencing the fire safety checks, or the fire alarm tests and staff were clear on who was responsible for completing these checks. The oversight systems for fire safety and provider's own internal monitoring systems had improved. Notwithstanding the progress made in relation to fire precautions, all issues had not been addressed by 31st of December 2024. Specifically, areas related to fire detection, fire containment and fire doors remained outstanding.

A restraint-free environment was not being promoted in line with national best practice guidance. There were restraints such as, bedrails in use with no evidence that alternatives had been trialled prior to a restraint being used. Assessments and care plans in this regard were vague and inconsistent in relation to content.

There was a clear policy in place in relation to the detection of abuse and safeguarding the residents. All staff had received training in how to identify and report a concern in relation to abuse. Staff who spoke with the inspectors were very clear about their responsibility to keep the residents safe and confirmed their knowledge of safeguarding.

Progress to implement the required improvements to the premises in respect of Castle unit was very limited. For example, surfaces and finishes including furniture and flooring in a large number of bedrooms continued to be worn and damaged and as such, did not facilitate effective cleaning. Four single en-suite bedrooms had been refurbished; inspectors viewed these rooms with the permission of the new resident admitted to each one of them. They had been refurbished to a satisfactory standard. However, residents living in Castle unit for some period of time were not prioritised to transfer into the upgraded bedrooms and remained living in bedrooms that had not been refurbished to date.

Medication management processes were safe and evidence-based.

Regulation 17: Premises

Notwithstanding the refurbishment of the four bedrooms in Castle, the inspectors found that works to upgrade the premises had not been carried out in line with commitments given by the registered provider. This has been a repeated finding.

- the corridor walls, communal room doors, hand rails and areas of flooring and furniture remained heavily damaged and scuffed in Castle and the premises appeared shabby and poorly maintained.
- not all bedrooms had appropriate curtains to support a home-like environment as referenced in the centre's statement of purpose. The screening in some of the occupied twin bedrooms was of disposable material, as seen in hospitals, creating a clinical look and feel in those rooms. Those screens were visibly unclean and were not appropriate for residential use.
- a number of bedrooms in the Castle unit were locked as they were not in use. The inspectors viewed some of these bedrooms and noted that they had not been refurbished to date.

Judgment: Not compliant

Regulation 25: Temporary absence or discharge of residents

The inspectors reviewed residents' records and saw that where a resident was temporarily absent from a designated centre, relevant information about the resident was provided to the receiving designated centre or hospital. Upon residents' return to the designated centre, the staff ensured that all relevant information was obtained from the discharge service, hospital and health and social care professionals.

Judgment: Compliant

Regulation 26: Risk management

There was a risk management policy available for review. It met the legislative requirements. There was evidence of some learning having been implemented post incidents that had been reported, as required to the Authority.

Judgment: Compliant

Regulation 28: Fire precautions

The revised programme of works had not been fully progressed to address all the previously raised concerns in relation to fire detection, fire containment and fire doors throughout the centre. Inspectors could not be assured of effective compartmentation within the building, for example, outstanding issues included;

- There was an electrical distribution communications control cabinet situated behind the nurses' station in Estuary B which was open to the evacuation corridor. There were no appropriate fire containment measures in place at this cabinet, which posed a significant risk that a fire in this area could prevent residents, staff or visitors from evacuating safely through the exit doors adjacent to the nurses' station.
- Fire door repairs been addressed in the other units, however in the Castle unit there continued to be non-fire-rated hinges and ironmongery on a number of fire doors. This would make them less effective at containing fires.
- Up-grading of fire rating roof window enclosures had not been completed in the Castle unit. Inspectors acknowledge the issues had been addressed in the remaining parts of the centre.
- Fire wall compartmentalisation to roof was not completed in Castle unit.

This is a repeated non-compliance, the provider was required to have had this work completed by the end of December 2024.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Medication management processes such as the ordering, prescribing, storing, disposal and administration of medicines were safe and evidence-based. There was good oversight with regular medication reviews carried out.

The inspectors observed good practices in how the medicine was administered to the residents. Medicine was administered appropriately, as prescribed and dispensed.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Care practices observed did not reflect the individualised and assessed health, personal and social care needs of each resident.

- There was no care plans in place to reflect the assessed needs of one resident who had been admitted to the centre over 48 hours.
- Three residents had not been assisted out of bed in a timely manner, as was their preference and outlined in their care plan due to staff shortages on the day of inspection.
- Wound assessments, corresponding care plans and records of wound care provided were not reflective of each other. For example, the records for wound dressings completed were not clear on what dressing was used to dress the wound, and not in line with the guidance outlined in the care plan.
- Staff were over burdened with the completion of 15 to 30 minute checks on residents post a fall. Inspectors found that these checks were completed, however on an hourly basis and therefore not in accordance with their care plan.
- For those residents at risk of absconsion, the care plan was not implemented in practice and the safety check records were not appropriately maintained.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

Restrictive practices were not being applied in line with national policy on restraint and evidence-based practice. For example;

- some residents with bed-rails in use had no restraint or risk assessment completed and therefore such practices were not in line with the centre's own policy or national policy.
- some residents with bed-rails in use had a restraint assessment completed, however the assessment did not state what alternatives were trialled and tested prior to bed-rails being used as a form of restraint.
- the reasons for using restrictive practices were not clearly assessed or recorded, and were not always evidence-based. For example care plans stated that 'family wants bed-rails to be used', therefore the decision to use a form of restraint was not based on a clinical assessment of the resident.
- Inspectors observed that residents living in one of the units could not access the secure enclosed garden independently.

Judgment: Not compliant

Regulation 8: Protection

The inspectors found that all reasonable measures were taken to protect residents from abuse. There was a policy in place which covered all types of abuse and the inspectors saw that all staff had received mandatory training in relation to detection, prevention and responses to abuse.

There was a rigorous recruitment procedure in place. Staff had An Garda Siochana (police) vetting prior to starting work in the centre.

The provider was a pension-agent for a number of residents. The inspectors were assured that monies collected on behalf of residents were being lodged into a residents' account, in line with the Social Protection Department guidance.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 26: Risk management	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Talbot Lodge Nursing Home OSV-0000182

Inspection ID: MON-0046893

Date of inspection: 24/04/2025

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:
The Provider acknowledges the inspector's findings regarding delays in call-bell response and the impact of staffing levels on resident care and routine, including delays in mobilisation and meal service. While 19 clinical staff were rostered on the day of the inspection for 84 residents, the Provider recognises that staffing adequacy must not only meet numerical targets but must also reflect real-time dependency levels, unit-specific needs, and resident acuity.

In response to this, a full review of staff allocation across the four units is currently underway, taking into account current dependency assessments, peak activity times, and resident flow patterns. On completion of this review, the Provider will reassign clinical staff as needed and ensure that resource distribution is aligned with clinical demand.

Where necessary, additional clinical resources will be introduced to maintain safe, person-centred care standards.

Further actions being taken include:
• Updating dependency assessments fortnightly, or more frequently where significant changes occur.
• Realigning staffing rosters to match unit-specific demands and times of peak activity (e.g. mornings, meal services).
• A full upgrade of our call bell system has been actioned and is scheduled for completion by July 31st.
• Weekly audits of call bell response times will be implemented to monitor improvements and identify any ongoing delays.
• CNM's will review daily response times during handover and address delays immediately.
• Results of weekly audits to be shared at the clinical governance meeting to drive accountability and continuous improvement.

• Any persistent delays identified through audits will trigger a root cause analysis and

corrective actions.
• Engaging staff and residents in feedback loops to validate staffing sufficiency and ensure the care experience aligns with regulatory expectations.
• Providing ongoing supervision and support to staff through the oversight of a supernumerary CNM/ADON, ensuring they are equipped to escalate concerns promptly when staffing pressures arise.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
All staff will receive training on a human rights-based approach to care, with sessions scheduled to commence within July and be completed by August 01st.

Training on restrictive practices and the use of alternatives to physical restraint will be prioritised and completed for all relevant staff. One onsite session has already been completed on June 19th and further onsite sessions to be scheduled to capture all RGN's and HCA's. This will be completed by August 22nd 2025.

A full audit of bed rail use is underway to ensure appropriate risk assessments are in place, alternatives have been trialled, and documented consent is obtained where required. This will be completed by July 31st.

Staffing levels and allocation are currently being reviewed to ensure they meet the dependency needs of residents. Adjustments to allocations of the clinical staff and rosters will be made accordingly. This will be completed by July 18th.

Designated shift leaders are being assigned on each unit to strengthen staff supervision and support. This will be overseen by a supernumerary CNM/ADoN on a daily basis.

Daily management walkarounds and supervision audits have been implemented to monitor restraint use and care delivery practices.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• Resident Safety Checks
o The PIC has reinforced with all staff through handover and meetings the importance of completing safety check records contemporaneously to ensure accuracy and accountability.
o A daily audit of safety check documentation will be implemented by the CNM to ensure compliance.
o A CNM/RGN handover process will be implemented at the end of each shift and will data on completed safety check records.
• Staff Rosters
o HR have conducted an immediate review of rostering processes to ensure the planned and actual rosters accurately reflect staff on duty.
o A strategy has been introduced requiring real-time updates to rosters for any staff changes (e.g. sick leave, redeployment).
o Responsibility has been assigned to the Person in Charge or CNM to verify and sign off on the accuracy of rosters daily.
o Roster audits have been included in monthly governance audits to ensure sustained compliance.
• Monitoring and Oversight
o The CNM's has been designated to carry out weekly spot checks on both resident safety documentation and rosters. Auditing processes have commenced immediately and will continue on an ongoing basis.
o Findings and any corrective actions will be taken and reported at the monthly Governance and Management Meeting.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Significant progress has already been made to strengthen the governance and management structure. Both vacant Clinical Nurse Manager (CNM) positions have now been recruited into, with one post-holder commenced on June 17th and the second commenced on July 01st.
• To ensure consistent leadership and oversight, the Provider has put in place a rota for senior management coverage during any future periods of leave, ensuring there is always a suitably qualified person available on-site to support day-to-day operations.
• A full review of staffing levels and allocation is currently being undertaken to ensure the centre has adequate numbers of staff to meet residents' assessed needs. Additional healthcare assistant (HCA) hours have been introduced, and a recruitment plan is in place to address any remaining vacancies. Dependency levels are being monitored weekly to adjust staffing in line with changing resident needs.

• To strengthen clinical oversight and the quality of care, a programme of enhanced auditing has been implemented. Care plan audits are now carried out weekly by the CNM team, with actions monitored to ensure timely implementation. A system of governance meetings has been introduced where findings from audits and resident feedback are reviewed by the management team and Clinical Director.
• Concerns raised by residents during meetings have been revisited and are being addressed in collaboration with the catering and care teams. A resident satisfaction survey is also being conducted to ensure that actions taken meet resident expectations. This will be completed by July 31st.
• In relation to fire safety, and as outlined in previous submissions, significant remedial fire upgrades were completed prior to the inspection, and all remaining works have since been finalised.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Provider acknowledges the findings regarding the condition of the Castle unit and is committed to ensuring that all areas of the premises are upgraded and maintained to provide a safe, comfortable, and home-like environment in line with the centre's Statement of Purpose. Immediate and ongoing actions are being implemented to address the concerns raised.

• Refurbishment of Corridor Walls, Doors, Handrails, and Flooring
o A full assessment of all damaged surfaces in corridors, communal room doors, handrails, flooring, and furniture in the Castle unit has been completed.
o A refurbishment schedule has been agreed with contractors and works are ongoing, with priority given to high-traffic areas and communal spaces.
o Target date for completion: August 10th, 2025.
• Upgrading Curtains and Room Furnishings
o All bedrooms will be reviewed to ensure curtains and furnishings meet the standard for a home-like environment.
o Disposable hospital-style screens in twin bedrooms are being replaced with permanent, fabric-based privacy solutions have been ordered since the inspection. Cleaning protocols for all soft furnishings will also be reviewed and enhanced.
o Target date for completion: August 10th, 2025.
• Refurbishment of Unused Bedrooms
o All currently unused and locked bedrooms in the Castle unit are scheduled for refurbishment to ensure they are ready for occupancy when required.
o A detailed works plan for these rooms has been finalised and the provider is working with contractors to ensure timely completion.
o Target date for completion: August 10th, 2025.

A Weekly audit is being monitored by the Facilities Manager to proactively identify and address any wear and tear across the premises.

Refurbishment progress is being reviewed at weekly management meetings until all works are completed.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Significant remedial fire upgrade works, (see list below), had been completed in the centre prior to the date of inspection.
Completed works prior to inspection included:
• Upgrade of internal signage and emergency lighting, with additional units installed (Completed October 2024)
• Upgrade of external emergency lighting, with additional units installed (Completed October 2024)
• Fire-stopping works completed in Castle, Seabury, Estuary C, and Estuary B boiler rooms (Completed February 2025)
• Additional compartment walls installed, including in the kitchen (Completed April 25)
• External door compliance works (locks removed or blanked – July 2024)
• Installation of new 60S fire doors in the reception area (Completed Jan 25)
• Full remedial works to fire door sets, including closers and seals:
o 160 doors upgraded in total (26 prior to October 2024 inspection; 134 completed since)
o Upgrades included:
· Thumb locks
· Hinges
· Smoke seals
· Fire seals
· Door closers
· Gap adjustments
• Service penetration fire-stopping

All outstanding issues identified on the day of inspection have since been addressed and completed.
• The electrical distribution board in Estuary B had been commissioned for completion in January 2025; however, due to contractor availability, this was delayed. We confirm this work was fully completed on June 17th, 2025.
• Fire door repairs were completed across all three units of the centre. At the time of inspection, work in the Castle unit was ongoing. We confirm this has since been finalised.
• The upgrading of fire-rated roof window enclosures had been commissioned earlier this year and was completed on June 30th, 2025.
• Compartmentalisation of the Castle unit roof area was ongoing at the time of inspection, and we confirm this has now been completed.

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:
The Provider acknowledges the findings identified during the inspection and has taken immediate and ongoing actions to ensure that care practices reflect the individualised and assessed health, personal, and social care needs of all residents.

Actions Taken & Planned to date include:

o All residents admitted to the centre will have comprehensive assessments and care plans completed within 48 hours of admission, as per regulatory requirements.
o An admission audit has been introduced to ensure compliance with this timeframe and will be overseen by the CNM/ADoN.
o Staffing levels and allocation are under review to ensure residents are assisted out of bed in a timely manner, according to their preferences and outlined care plans.
o Allocations of care staff have been reviewed at peak times to support morning/bedtime routines. An additional morning and evening shift has been implemented to facilitate this.
o Refresher training will be scheduled for all nursing staff on completing wound assessments, care plans, and wound care records accurately and in alignment. This will be completed by August 08th.
o Frequent wound care audits have been implemented to monitor compliance and quality of documentation by the CNM/ADoN.
o Staff have been reminded of the importance of adhering to prescribed monitoring intervals (e.g., 15- or 30-minute checks) post-fall.
o Clinical oversight of post-fall monitoring has been enhanced by the nurse in charge, and spot checks will be completed daily to ensure adherence.
o All care plans for residents at risk of absconsion are being reviewed and updated where necessary. This will be completed by July 25th.
o Staff have been reminded on implementing and documenting safety checks contemporaneously.
o The CNM and the Nurse in Charge will now verify that all safety check records are completed as required.
o Monthly audits on care planning, wound care, and post-fall monitoring will be reported to the management team.
o Monthly compliance reports will be submitted to the Provider to ensure sustained improvement.
o The CNM and senior nursing team will provide enhanced supervision and support to staff to embed these practices into daily care delivery.

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:
Immediate and ongoing actions are being implemented to bring the centre into compliance with Regulation 7.

Actions Taken & Planned to date include:

• Restrictive Practice Assessments
o All residents with bed-rails in use will have a full restraint assessment and risk assessment completed in line with the centre's policy and national guidelines.
o Audits of current bed-rail use are underway to ensure all residents have appropriate documentation in place.
• Trialling of Alternatives
o Staff have been reminded of the requirement to document alternatives to restraint trialled prior to the use of bed-rails.
o A standardised Restrictive Practice Decision-Making Form has been reinforced with RGN's to ensure clear documentation of:
· Alternatives considered and trialled
· Clinical justification for the use of restraint
· Multidisciplinary team input
• Decision-Making and Care Plans
o All care plans for residents using restrictive practices are being reviewed and updated to reflect resident-centered clinical assessments, rather than family preference alone, unless clinically appropriate and in consultation with the resident.
• Staff Training
o All staff will complete training on the National Policy on the Use of Restrictive Practices and a human rights-based approach to care by August 22nd.
• Access to Outdoor Spaces
o The secure enclosed garden will be assessed to identify measures to facilitate residents' independent access where safe and appropriate. The code to access the garden has been discreetly displayed in a "butterfly" image so residents are aware.

Monthly audits of all restrictive practices and documentation will be conducted by the CNM/ADON, with oversight from the Person in Charge.

Findings from audits will be reported to the management team and reviewed at governance meetings to ensure sustained compliance.

All actions to be fully implemented and audited by August 22nd.

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	22/08/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	22/08/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/06/2025
Regulation 17(1)	The registered provider shall ensure that the	Not Compliant	Orange	10/08/2025

	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.			
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	10/08/2025
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	31/07/2025
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	29/08/2025
Regulation 23(1)(b)	The registered provider shall ensure that there	Not Compliant	Orange	04/07/2025

	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.			
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	31/07/2025
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	30/06/2025
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	30/06/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for	Not Compliant	Orange	30/06/2025

	detecting, containing and extinguishing fires.			
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).	Not Compliant	Orange	08/08/2025
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.	Not Compliant	Orange	04/07/2025
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	22/08/2025