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:	03 September 2025
Centre ID:	OSV-0000182
Fieldwork ID:	MON-0048002

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:	67

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 3 September 2025	07:00hrs to 15:45hrs	Sheila McKevitt	Lead
Wednesday 3 September 2025	07:00hrs to 15:45hrs	Manuela Cristea	Support
Wednesday 3 September 2025	07:00hrs to 15:45hrs	Frank Barrett	Support

What residents told us and what inspectors observed

Residents living in Talbot Lodge Nursing Home gave mixed feedback about the service they received. They said that they felt safe, and valued the care they received from staff. The inspectors spoke with approximately ten residents and three visitors about life in the centre. Residents said that things had improved, in particular staffing levels during the day. However, two different relatives and one resident said that staffing at weekends and in the late evenings was an issue. Those spoken with said the negative impact of this was that their loved one was delayed in being assisted with getting washed and dressed, which they felt was not good enough.

Inspectors arrived unannounced to the centre in the early morning and were met by a health care assistant. Two staff nurses spoken with did not know who was in charge on night duty and did not have access to the roster for the centre. After informing both nurses about the inspection process, the inspectors undertook a walk around the centre. Inspectors met with residents and staff, and observed both the care environment, and the quality of care, being provided to residents. Overall, the environment was quiet and calm and, residents' calls for assistance were answered promptly.

Inspectors saw that the main reception area was enclosed in a wooden structure with high glass panel. None of the night staff could access this reception area, the door to which was locked. Staff did not know the code for the keypad or have a key for the door. This was particularly concerning as the fire panel for the Seabury unit was located behind the reception area and therefore was not accessible to night staff in the event of fire at night.

Inspectors spent the early morning talking with night-time staff and observing the care practices and the handover process (the exchange of relevant information in respect of residents between the night-time and day-time staff). Following this, inspectors met with the chief operating officer, the regional manager and the assistant director of nursing who was deputising for the person in charge at the time.

Improvements were noted from the last inspection in Castle unit, most of which had been redecorated and refurbished to a satisfactory standard. However one twin bedroom, a dining room and one sitting room had yet to be completed. There were some other minor issues outstanding which are further detailed under Regulation 17: Premises.

Inspectors observed that some floors, particularly the dining room and kitchenette floors, were visibly dirty. The dining room floors were cleaned by mid-morning. However, the kitchenette floors, stainless steel equipment, sinks, work surfaces, shelves and fridges were visibly dirty as further detailed under Regulation 17: Premises. Inspectors observed gaps in house-keeping staffing levels with planned

absences not replaced. The house-keeping supervisor was working on one of the four units completing house-keeping duties for the day and therefore not available to supervise the rest of the team.

Inspectors observed that planned daily activities were displayed on information boards in each unit. The schedule included exercise classes and live music. While walking around the centre and chatting to residents in communal areas, inspectors observed activities taking place, including a live music session in the afternoon. Residents were given the choice to participate and residents said they enjoyed the bingo and the yoga.

Residents spoke positively about staff, describing them as 'gentle', 'sympathetic' and 'great', but mentioned that they were 'always in a rush, always under pressure'. Two residents said that there were only two staff on each unit at night and this meant that they often had to wait for a long time to be assisted into their bed/bedroom. The inspectors confirmed that on three of the four units there were two staff on night duty. Staff confirmed that residents do have to wait as when the staff nurse is administering night medications and the health care assistant is offering the residents night drinks there is no one free to assist the residents to bed. This had been high-lighted as an identified required action in one of the unannounced night inspections carried out by the management's own team; however the management team could not identify any action taken to address the issue by the time of the inspection.

Some residents spoke with inspectors about the quality of the food they received and highlighted that it was good and they received a choice. Inspectors saw that the choice displayed on the menu was salmon however this was not what was offered on the day. Inspectors observed that instead, residents were served hake and when they queried the discrepancy, they were told the usual chef was not on duty.

Inspectors reviewed the nutritional care plans arrangements for residents at risk of losing weight and saw that recommendations made by dietitians and other healthcare professionals were not always implemented in practice. In conversations with inspectors healthcare staff were not aware of residents' specific nutritional requirements as outlined in the individualised care plans. Staff, especially newer staff, showed the inspectors the handover document which they relied on and which they used as their guide to delivering care. However, a review of this information found that the details were not current or accurate and did not reflect the actual needs of the residents, as described in their care plan. More experienced staff said that they did not use the handover sheet as they knew the residents, however they confirmed that they were not aware of the information contained in residents' care plans. They confirmed that they had access to the electronic care planning records, but did not always have the time to check.

Residents were observed receiving visitors throughout the inspection in both their bedroom accommodation, and designated visiting areas. Relatives said there were no restrictions on visitors.

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 representation to a notice of proposed decision to attach a restrictive condition to the registration to stop all admissions to the designated 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 some of these concerns were substantiated, as further set out in this report. The findings of this inspection were that the registered provider was in the process of putting management structures and systems in place to ensure that the service provided was safe and appropriately monitored. A clear organisational structure, detailed on paper was not fully in place and the management systems of monitoring and oversight were ineffective which significantly impacted on the quality and safety of the care provided to residents.

Knegare Nursing Home Holdings Limited is the registered provider of Talbot Lodge Nursing Home. In July 2024, in response 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, a restrictive condition preventing admissions to two units was attached to the registration of this designated centre. That condition remains 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 the 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 meeting the requirements of the restrictive condition of the registration in respect of completing all fire-related works by 31st of December 2024.
- had inadequate staffing levels to meet the health and care needs of the residents in a timely manner.
- did not adhere to their commitment to renovate the remaining Castle Unit where admissions were stopped.

Following a warning meeting, the provider applied 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 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, which included the appointment of a new person in charge, two clinical nurse managers (CNMs) and the planned appointment of a CNM specialist in September 2025.
- to implement effective systems of management and oversight to monitor the quality and safety of care provided to residents by ensure the availability of a CNM seven days a week to supervise practices and oversee the service.
- to implement the actions committed to in a compliance plan to bring the centre into compliance with the regulations.

During this inspection inspectors found high levels of turnover, with three Clinical nurse managers (CNMs) and the person in charge leaving since the last inspection. The operational management team comprised of new people, with the exception of the assistant director of nursing. A new person in charge and two new CNMs had started their roles, and there were plans for two other CNMs to start in mid-September 2025. The newly appointed person in charge was on planned leave at the time of the inspection, and the assistant director of nursing was deputising in their absence and was supported by the group clinical services director. Inspectors found that the extent of changes to the organisational structure had resulted in responsibility and accountability for key aspects of the service being unclear, leading to a a failure to appropriately monitor critical elements of service provision, particularly the delivery of safe and quality care to the residents, in line with their assessed needs and care plans.

In line with commitments given in the representation letter, the inspectors found that there was at least one clinical nurse manager (CNM) on duty every day, seven days per week, and that there was enhanced oversight of staff rosters and allocation had improved. However, significant gaps in clinical supervision were evident on night duty where nobody was assigned responsibility for the designated centre. The lack of a cohesive roster and an identified responsible person at times of increased risks such as night-time lead to significant uncertainty and risks to the oversight and effective delivery of a safe service at night-time.

In the representation, the provider stated that all remedial fire safety works including fire detection, compartmentation, containment and fire doors have been completed and signed off by a competent person. Inspectors found that a lot of work had been completed, however fire safety concerns persisted at the centre. The management of fire safety is discussed further under Regulation 23: Governance

and management, and further fire safety issues are dealt with under Regulation 28: Fire Precautions.

In the representation, the provider stated that the premises is fully refurbished in the Castle unit with all bedrooms repainted and furnished. Inspectors could see that most areas had been completed in accordance with this commitment, however a bedroom, a sitting room and a dining room had not been repainted or furnished.

Training records were maintained and updated accordingly. The inspectors were assured that all staff working with residents in the centre had completed all the required mandatory training. All clinical staff were in the process of completing training on a human rights-based approach to care with 50% having completed all four theory modules of this training and all staff were due to complete face-to-face training on this subject in early October 2025.

Inspectors followed up on the management of records, and found that while some progress had been made to improve record-keeping, however further actions were required in respect of residents' records as outlined under Regulation 21: Records.

Regulation 15: Staffing

There was a sufficient number of staff rostered on duty to ensure the care needs of the residents were met in a prompt and safe manner. The staffing levels were adjusted according to the number and assessed needs of residents on each unit.

There was one qualified nurse on duty on each of the units each day and each night.

Judgment: Compliant

Regulation 16: Training and staff development

The supervision of staff and residents on night duty was not clear. Staff were not clear on who was in charge on night-duty.

In addition the system in place to supervise staff failed to recognise or respond to:

- the absence of recorded evidence of 15 minute location and the practice of retrospective recording.
- the failure to complete neurological observations in line with the centre's falls management policy.
- the absence of records to evidence that resident who required regular repositioning received the care they required.

Judgment: Substantially compliant

Regulation 21: Records

Residents' individual care records were not fully completed to account for the care provided at all times and gaps were found in the care and treatment records as follows:

- One resident at risk of absconsion was assessed as requiring 15 minute location checks, but there was no recorded evidence of these checks being completed. In other example where such care records were maintained, the inspector saw that they were retrospectively populated by staff. This practice was observed in two out of the four units in the designated centre.
- For one resident who had an unwitnessed fall, gaps in the records indicated they did not have neurological observations completed in-line with the centre's falls management policy.
- One resident whose care plan stated they were to be repositioned when in bed did not have repositioning records completed over a three week period.
- The centre's staff roster was not available to night staff on night duty.

Judgment: Substantially compliant

Regulation 23: Governance and management

The organisational structure, as described in the centre's statement of purpose was not fully in place and the specific roles of the nurse management team in place were not clearly defined. As a result, accountability and responsibility for the oversight and monitoring of key aspects of the service were unclear. This included the oversight of the house-keeping staff, the catering staff and nursing care practices. This resulted in the failure to appropriately monitor critical elements of service provision, particularly the delivery of safe and quality care to the residents, in line with their assessed needs and care plans.

The consequences of not having a complete organisational structure embedded impacted negatively on the service provided as the provider could not ensure it was safe and appropriately monitored. This was evidenced by;

- Ineffective oversight arrangements in place to ensure the needs of all residents were met, particularly in terms of the arrangements for health care, assessments and care planning. As a result, residents were exposed to risks and did not receive the standard of care necessary to safeguard their health and wellbeing.

- Ineffective oversight arrangements of some areas of the environment, such as the pantries and kitchenettes in two of the units which were visibly not clean.
- Ineffective system of communication between staff. Key information in relation to residents' mobility care needs, resuscitation status, falls risk , and nutritional requirements were not known to all staff responsible for the care of the residents. An immediate action was given to the provider in this respect and satisfactory assurances were received following the inspection.
- The systems for auditing key performance indicators such as wounds and pressure sores had recently identified inconsistencies between the recommended treatment plans and the lack of availability of the required dressings. Inspectors were informed that alternative arrangements were being sought with the dispensing pharmacy, however no follow-up review of the residents impacted by this for over two months had been considered.
- Recommendations arising from spot checks and night-time visits by clinical supervisor had not been acted upon. This included a review of night-time staffing levels on some of the units to ensure appropriate resources to meet the needs of all residents.
- Further fire safety management was required to ensure that fire safety priorities within the centre were continually addressed. A thorough review by a fire safety consultant in the form of a fire safety risk assessment (FSRA) to outline these priorities, was committed to by the provider on the day of inspection.
- Staff training and understanding of the evacuation restrictions imposed by having large bedroom compartments required further management oversight, as outlined under Regulation 28. An immediate action was given to the provider and some assurances were received following the inspection that improved fire drills were achieved and that continuous quality improvement action will be taken.
- Further works were required in order to comply with the requirements of the condition placed on the centre in relation to the upgrade of rooms.

Judgment: Not compliant

Quality and safety

Inspectors found that aspects of the quality and safety of care provided to residents were impacted by inadequate governance and management arrangements and oversight described under the Capacity and Capability section of this report. This inspection identified that the delivery of care required further improvement, particularly in relation to assessments and care planning and implementation of treatment recommended by allied professionals. In addition, the inspection found that the premises and fire precautions required further work.

The provider had committed to taking action to improve the quality of the nursing documentation with regard to the residents' individual assessment and care plans following the last inspection. While there was evidence that residents' needs had been assessed using some validated assessment tools, the care plans reviewed were not always informed by these assessments, and 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 a deterioration in their condition was observed.

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. However, the inspectors found that the recommendations of the health care professionals were not always implemented in practice. This significantly impacted the health and welfare of residents and demonstrated that the systems in place to ensure the provision of appropriate health care to residents were ineffective. This issue was compounded by a lack of robust auditing and monitoring as described in the earlier section of this report.

The refurbishment of Castle unit was almost complete. This outstanding work together with some additional minor issues are discussed further under regulation 17: Premises.

Inspectors reviewed arrangements in place at the centre on the day of inspection to protect residents from the risk of fire. While the centre had been undergoing improvement works to upgrade fire safety, a number of areas required further work. The policy referred to fire safety risk assessments (FSRA) being completed regularly and that any identified issues would be addressed in line with the recommendations. However, the documents reviewed were not sufficiently detailed to indicate the level of risk associated with fire safety related concerns.These are discussed further under Regulation 28: Fire Precautions.

Regulation 17: Premises

Improvements were required of the registered provider to ensure that the premises is in line with the Statement of Purpose and the floor plans for which it is registered. For example:

- A large storage space for the storage of items used by the centre, was not outlined as part of the registered floor plans as required.

Improvement was required of the registered provider, having regard to the needs of the residents at the centre, to provide premises which conform to the matters set out in Schedule 6 of the regulations. For example:

- Not all areas of the designated centre were clean and well maintained. For example, the kitchenettes and the equipment within were visibly unclean.
- Not all areas of the centre were appropriately equipped to uphold residents' rights and support safe care delivery. For example, in a sample of residents' en-suites inspectors observed that the hand-washing sinks were not fitted with plugs and therefore residents could not use these sinks to wash or shave.
- Some bedrooms required additional screening to ensure residents' right to privacy was upheld.
- Lockable storage was not available in all resident bedrooms. This was noted in some of the recently upgraded rooms also.
- A wardrobe in one of the refurbished rooms was damaged with broken hinges.
- A small number of rooms on Castle unit had refurbishment in progress.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider did not fully provide adequate means of escape, including emergency lighting, for example:

- Layout plans posted on walls throughout the centre did not reflect the compartment lines as they were on the day of inspection.
- A large communications cabinet at the nurses station posed a significant risk to the escape route,

The registered provider did not ensure that those living (in so far as is reasonably practicable) and working are aware of the procedure to be followed in the case of a fire. For example

- The provider had not practiced different senarios, including high risk areas.
- Access to the reception area by staff was restricted which meant that staff could not access the fire alarm panel to identify the location of a fire or to silence the alarm, if appropriate.

Some examples were seen where the registered provider did not make adequate arrangements for containing fires. For example:

- While new fire doors had been installed in some areas, issues persisted with the fire doors in the centre such as inadequate doors on corridors which were indicated as providing compartmentation.

- Ongoing fire door checks were not identifying issues with door closers, doors that were damaged and the inadequate fire rating of hinges and handles. A door separating the kitchen from the dining room area was in extremely poor condition.
- Compartmentation at the centre required review, as the compartments where the bedrooms were located were larger than management and staff were aware of.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Notwithstanding the comprehensive assessments completed on admission. Improvements in nursing documentation was required to ensure residents' needs were met. For example;

- There were inconsistencies between information in residents' care plans and the care being delivered by staff. For example, one resident was assessed as being at high risk of malnutrition and had a detailed special diet prescribed in their nutritional care plan, however staff spoken with did not have knowledge of this resident's special diet.
- End-of-life care plans reviewed were generic in content, they did not provide enough detail to staff to ensure person-centred care in accordance to the resident's wishes were provided to a resident at this time of their life. Staff were not aware of key information in respect of clinical decisions such as resuscitation status in the event of a cardiac arrest, and in fact the information contained within the handover sheet in this respect was incorrect.
- The information in some care plans was duplicated and was not consistent with the information handed-over to staff at the morning handover meeting.
- The care outlined in some care plans was not being implemented in practice. For example, one resident's care plan stated they were receiving one-to-one care, however staff stated this was no longer the case and the resident was now on 15 minute location checks.
- Risk related to residents assessed at risk of absconsion was not appropriately managed. For example, one resident's care plan stated they required to be on 15 minutes checks due to a very high risk of absconsion. There were no records maintained for the previous three weeks as the previous log book had run out and no replacement had been ordered. Another resident assessed as high risk was on hourly checks.
- One resident with two bed-rails in use had no bed-rail risk assessment in place and it was not clear from the care plan what if any alternatives had been trialled and failed prior to restraints been used.

Judgment: Not compliant

Regulation 6: Health care

Notwithstanding the fact that members of the multi-disciplinary team were accessible to residents, inspectors were not assured that their recommendations were implemented in practice. For example:

- One resident who had been recently assessed by the physiotherapist had recommended that the resident was to be assisted by two staff. Resident's care plan stated the resident required the assistance of one staff and the handover information sheet stated the resident was independent. Staff believed the resident to require assistance of one.
- Three residents with pressure wounds who had been reviewed by the tissue viability nurse and prescribed a specific dressing regimen did not benefit from that treatment as the pharmacy had difficulties sourcing these dressings.There was no evidence of staff seeking suitable alternative treatments and in some examples the inspectors saw that professional expertise was disregarded.
- There was a lack of assurance that residents received care in line with dietitian's recommendations and treatment, as residents assessed as requiring High protein High calorie diet were not provided with it.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

The designated centre's policy was available for review. There were appropriate and care plans which reflected the residents' individual needs, known triggers and known de-escalation techniques.

The provider was actively promoting a restraint-free environment, in line with national policy. Alternatives to restraint were in use where assessed as being suitable. The use of restraint was in the process of being reduced.

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	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Compliant

Compliance Plan for Talbot Lodge Nursing Home OSV-0000182

Inspection ID: MON-0048002

Date of inspection: 03/09/2025

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 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
A Staff allocation book has been implemented for each unit, and we have included the staff nurse in charge at nighttime. Additionally, the name of the night nurse in charge is visible on the white board in each unit to ensure all staff, residents and visitors are made aware of the person responsible. All staff were made aware of same during the staff meeting.

The CNM/CNS/ADON- do a daily audit on safety checks, turning charts, and touch care recording to ensure the residents' needs are met as per their care plan and staff are cognizant of the care needs for each resident. A carer guide is printed daily during handover and distributed to all HCAs to ensure they have quick and easy access to all information relevant to the residents. The guide is reviewed day and night by the staff nurse to reflect any changes in resident's care plans after review by any Allied professionals.

Management team have reviewed all the residents' safety checks and increased the safety checks to 30 minutes based on risks identified to improve compliance, and ensure recordings are completed timely. Paper based recordings have been discontinued to ensure timely recording on the electronic system to promote best practice align with resident's safety, and to avoid retrospective recordings.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
All 15-minutes checks have been increased to 30 minutes to ensure compliance in recording, and paper recording has been discontinued. All safety checks are recorded on the electronic system. This has been implemented, monitored and daily audited to ensure improvement in timely recording. Findings are discussed with staff to ensure effective communication and set realistic expectations from care staff.

A post fall neuro check list has been created to avoid gaps in recording from one team to the other. The CNM/CNS are responsible for checking that all Neuro-observations recordings are completed and any findings are communicated with all staff nurses to ensure compliance and best practice as per policy.

The CNM/CNS are assigned daily tasks to check touch care recordings and discussed with the team to ensure timely recording. Care guide has been created for each care staff to ensure they have adequate information about each resident's care needs and record them once task is completed. Touch care recordings are closely monitored by CNM/ADON/ and the floor supervisor weekly and findings are discussed with the team on the day to provide feedback and aim for ongoing compliance.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
We are committed to implementing robust corrective actions to ensure the safety, wellbeing, and dignity of all residents.
Organizational Structure and Accountability
• A revised organizational chart has been developed and embedded into the revised Statement of Purpose, which was submitted to the chief inspector on the 21st October.
• The revised Statement of Purpose consists of clear role descriptions for all members of the nurse management team that have been defined to ensure accountability and oversight.
• Housekeeping and catering departments will now report directly to DON and the facility manager. To ensure oversight and accountability, we have implemented daily monitoring and walkaround with DON to focus on improvement.
• A new Environmental Hygiene Checklist will be introduced for pantries and kitchenettes, with daily monitoring and monthly reviews.
Communication Systems
• A structured handover protocol has been implemented and updated daily to ensure all staff are aware of residents' care needs, including mobility, resuscitation status, falls risk, and nutritional requirements.
Clinical Audits and Follow-Up

• The CNM/CNS/ADON do an audit in residents' records post visit to ensure recommendations provided by Allied professionals have been implemented and put into practice.
• A follow-up protocol has been introduced to ensure residents who will be prescribed for dressing supply are reviewed within 48 hours post recommendations TVN or allied professionals will be informed immediately if dressing material is out of supplier chain to seek an alternative option. A monthly stock check for all dressing materials are conducted to ensure mostly used dressing materials are available in the nursing home. It was communicated to all staff nurses to inform CNMS/ADON/CNS if any dressing is not in stock and to place a timely order to the pharmacy before running out of dressing materials.
Staffing and Night-Time Oversight
• Night-time staffing levels have been reviewed and adjusted based on resident dependency levels in one unit. Twilight shift has been introduced on the 6th of September to ensure appropriate support is provided to the team. A senior nurse is always rostered to provide support and guidance to staff nurses. The PIC/ ADON is on an on call rota alternate week to provide any additional guidance over the phone.
• Recommendations from clinical supervisor spot checks are now tracked through a Quality Improvement Log with assigned actions and deadlines.
Fire Safety Management
• A fire safety consultant has been engaged to complete a Fire Safety Risk Assessment (FSRA) in the high-risk unit-Estuary B, with the expected visit in the 1st week of November.
• Staff training on evacuation procedures in the identified large bedrooms compartmentation has been enhanced, with weekly fire drills.
Room Upgrades
• The works required in the bedrooms has now been completed and photos have been sent to the chief inspector on the 21st of October to ensure we comply with the requirements of the condition placed on the Centre.

We are committed to continuous improvement and will ensure that all corrective actions are fully implemented, monitored, and sustained. A follow-up internal audit will be conducted within 4 weeks to assess progress and effectiveness of the systems put in place.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
To ensure compliance with the statement of purpose and the floor plans for which it is registered:

• The revised floor plan, including the outdoor shed, now reflects on the novel Statement of purpose and was submitted to the chief inspector on the 21.10.2025.
• A daily cleaning checklist has been implemented in all kitchenettes, and the main

kitchen with assigned role and responsibility to the kitchen assistant on duty to maintain daily cleanliness. A weekly audit by the head chef has been included to ensure sustainability and compliance. Additional oversight is conducted by DON daily and weekly by the Facility Manager.
• All hand washing en-suite sinks have been fitted with plugs to support residents with personal hygiene; washing and shaving.
• Additional screening to provide residents' privacy in shared bedrooms have been fitted, and photos were sent to the chief inspector on 21.10. One partition curtain is pending till the 4th of November.
• An audit was completed and missing lockable storage was fitted in all residents' wardrobes.
• The identified wardrobe with broken hinges was repaired and works completed.
• All the bedrooms in Castle are now fully refurbished to ensure residents have a homely environment.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• An updated layout plan to reflect current compartments, exit doors, and extinguishers have been ordered and will be on display in each unit to ensure visibility in all areas, and expected delivery is the 4th of November.
• We plan to relocate the large communication cabinet currently from the nurse's station by end of November, after confirmation from the engineer or else we will enclose the area.
• The registered provider has implemented two weekly fire drills including day and night scenarios, in the identified high-risk area due to large compartment bedrooms.
• The registered provider has implemented a revised access protocol to ensure all staff have access to the fire alarm panel in the reception area. Access code has been provided to all staff members and is also indicative on the daily handover sheets.
• All fire doors are checked and audited to ensure the Centre meets the required compartment standards to safely contain fire. An enhanced fire door inspection to identify missing hinges, closers, fire rating, and handles is in progress by the project manager in conjunction with an external company-Millmount.
• The damaged door between the kitchen and the dining room in Estuary B has been repaired with a compliant fire-rated door.
• The registered provider has engaged with an external fire safety consultant to review compartmentation layouts in the large compartment unit to ensure compliance, pending date for review from the consultant.
• Ongoing two weekly fire evacuation drills for day and night scenarios are conducted to ensure all staff are cognizant and confident about the policy and procedure to promote knowledge on the best and safe course of actions in case of a fire.

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 registered provider is committed to improving nursing documentation to ensure residents' needs are consistently met and care is delivered in accordance with assessed needs and as per residents' care plans. The following corrective actions have been implemented and monitored by the clinical team:

• The registered provider has put in place a robust system-care guide and improved handover structure to ensure information about the residents is communicated to all staff effectively and on time. All staff have easier and quicker access to information relevant to the residents' care needs.

• Assessments and care planning training were conducted in September for all nursing staff. The DON/CNS/and CNM conduct daily staff briefings to reinforce awareness of individual dietary needs, care guide provided daily to all care staff with up-to-date information regarding residents' care needs.

• A revised end-of-life care plan to include person-centered details aligned with residents' wishes are in progress. We plan to conduct training sessions by mid-November for all staff on documenting and communicating clinical decisions such as resuscitation status, preferences and wishes. The revised ed handover sheet contains resuscitation status for all the residents.

• An ADLs Care plan framework has been updated and implemented for all the residents which consists of correct information and eliminates the risk of duplication and incorrect entry.

• Monthly care plans audits are being conducted by the clinical team; findings and learning outcomes are shared with all relevant staff during monthly clinical meeting to promote safe and effective care for service users.

• Residents who are at risk of absconding are being monitored by staff and were made aware of the importance of adhering to care plans and ensuring correct safety checks are recorded as per the resident's risk level.

• All restraints in use have been reviewed by the restraint committee team, to ensure appropriate use. Care plans, consent and risk assessment have been completed for all types of restraints, including the care plans; indicating the type of alternatives which were in place. To ensure staff has knowledge with the use of restraints, training has been provided by the CNS to staff and is ongoing.

• Staff have been instructed to follow each recommendation provided by Allied professionals. ADON/CNM will do a monthly stock check to ensure all dressing supplies are in-house, staff nurses were informed to place the appropriate order immediately to the pharmacy. If dressing regimen is not in stock or not available in pharmacies, TVN will be informed immediately requesting for an alternative option.

• Similarly, for recommendations received by the dieticians-Type of diet is included in the carer's guide to ensure all care staff are aware of resident's dietary needs.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• Daily structured clinical oversight and spot checks by CNMs, CNS, and ADON will ensure that care and documentation aligned with advise by allied professionals and physiotherapists.
• Staff have been instructed to follow each recommendation provided by Allied professionals. ADON/CNM will do a monthly stock check to ensure all dressing supplies are in-house, staff nurses were informed to place the appropriate order immediately to the pharmacy. If dressing regimen is not in stock or not available in pharmacies, TVN will be informed immediately for an alternative option.
• Similarly, the recommendations received by dietician. Type of diet is included in the carer's guide and diet notification to ensure all care staff and kitchen staff are aware of resident's dietary needs.

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 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/10/2025
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Substantially Compliant	Yellow	21/10/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	03/01/2026

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	20/10/2025
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.	Substantially Compliant	Yellow	30/10/2025
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	21/10/2025
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	30/10/2025

Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/11/2025
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	30/11/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/11/2025
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	30/10/2025
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5,	Not Compliant	Orange	30/10/2025

	provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			