<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Talbot Lodge Nursing Home</th>
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</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000182</td>
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<tr>
<td>Centre address:</td>
<td>Kinsealy Lane, Malahide, Co. Dublin.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 846 2115</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:maryc@talbotgroup.ie">maryc@talbotgroup.ie</a></td>
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<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<tr>
<td>Registered provider:</td>
<td>Kinsealy Properties Limited</td>
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<tr>
<td>Provider Nominee:</td>
<td>Mary Clemenger</td>
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<tr>
<td>Lead inspector:</td>
<td>Jim Kee</td>
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<tr>
<td>Support inspector(s):</td>
<td>Mary O'Donnell; Nuala Rafferty</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>105</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>6</td>
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About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 3 day(s).

The inspection took place over the following dates and times

From: 02 July 2015 09:05  
      05 July 2015 16:10  
      09 July 2015 15:05  
To:    02 July 2015 22:10  
      05 July 2015 23:50  
      09 July 2015 19:40

The table below sets out the outcomes that were inspected against on this inspection.

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<td>Outcome 02: Governance and Management</td>
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<td>Outcome 05: Documentation to be kept at a designated centre</td>
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<td>Outcome 07: Safeguarding and Safety</td>
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<td>Outcome 08: Health and Safety and Risk Management</td>
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<td>Outcome 09: Medication Management</td>
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<td>Outcome 11: Health and Social Care Needs</td>
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<td>Outcome 12: Safe and Suitable Premises</td>
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<td>Outcome 13: Complaints procedures</td>
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<td>Outcome 18: Suitable Staffing</td>
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Summary of findings from this inspection

This was an unannounced inspection of the centre for the purpose of monitoring compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. This was the first inspection of this centre since the centre had increased in size and was now registered to accommodate 111 residents. There were 105 residents residing in the centre at the time of inspection.

During the inspection practices were observed, and relevant documentation reviewed including care plans, medical records, accident and incident logs, policies and procedures, and staff files. Inspectors also talked to residents, residents' family members and staff. The inspectors also met with the person in charge, the provider nominee and the general manager.

On the first day of the inspection inspectors raised concerns with the management about the staffing levels within the centre, and an extra member of staff was rostered to work the night shift from 8pm to 8am on one of the units. However after
the second day of the inspection, inspectors had further concerns staffing levels
across the centre at all times and an immediate action plan was issued to the
registered provider to ensure that this matter was addressed as a matter of urgency.
The outcome on suitable staffing was found to be in major non compliance with the
Regulations and this impacted on the safety and quality of care delivered to
residents. Judgments of major non compliance were made in relation to three other
outcomes, governance and management, health and social care, and suitable
premises. A judgment of moderate non compliance was issued for five outcomes,
documentation to the kept in the centre, safeguarding and safety, health/safety and
risk management, medication management and food and nutrition. The management
of complaints was compliant with regulatory requirements and the statement of
purpose was in substantial compliance with the Regulations.

Inspectors also issued an immediate action plan in relation to the nutritional
management of residents experiencing weight loss to ensure that appropriate
measures were put in place to address their nutritional needs.

The lack of staff to deliver and to supervise the delivery of care resulted in
institutional practices and poor outcomes for residents. Residents’ basic hygiene
needs were not met to an acceptable standard. There was inadequate supervision of
residents who posed a risk to their own safety or the safety of others. Care plans
were generic and did not support the consistent delivery of person centred care.
Care plans were not consistently implemented. The daily routine was designed to
facilitate inadequate staffing levels. The daily medications were administered starting
at 6 am and some residents who required assistance with meals were also given
their breakfast at 6.00 am. The centre had an outbreak of noro virus (winter
vomiting bug) but staff were not knowledgeable about the use of cleaning
substances or the need to increase cleaning routines during an outbreak of noro
virus. The absence of an effective system to monitor the quality of the care that
residents received was a serious deficiency in the governance and management of
the service. The immediate action plans were re issued to the provider because the
initial response to the two immediate action plans did not assure inspectors that the
serious issues raised were adequately addressed.

The action plan at the end of this report identifies those areas where improvements
were required in order to comply with the Regulations.
Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The inspector reviewed the statement of purpose for this centre, and found that it did not contain all of the information as specified in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

The statement of purpose described the ethos, aims and objectives of the nursing home, and also detailed the services and facilities to be provided for residents. However the statement of purpose did not contain the following information in sufficient detail:
- A description (either in narrative form or a floor plan) of the rooms in the designated centre including their size and primary function (including the number of residents accommodated in bedrooms)
- Details regarding any separate facilities for day care
- Arrangements for the management of the centre where the person in charge is absent
- Arrangements made for consultation with, and participation of, residents in the operation of the designated centre.

Judgment:
Substantially Compliant

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors determined that governance and management systems at all levels within the centre were ineffective to ensure the delivery of safe, quality care services to the residents especially those with higher dependency needs. The centre was also insufficiently resourced in terms of staff numbers and appropriate skills mix as detailed under Outcome 18.

There was a management structure in place within the centre. The senior management team consisted of the person in charge (Director of nursing), the provider nominee who was the director of quality, standards and training, and the general manager. There were also seven clinical nurse managers employed within the centre, with one clinical nurse manager on duty on Unit A, and one other clinical nurse manager on duty covering units B, C and D. from 8am to 8pm.

There was a system of auditing in place within the centre that included health and safety audits, hygiene audits, external audits of catering, audits of transfers to acute hospitals, audits of notifications, audits of accommodation provided to residents and falls audits. The centre had also recently surveyed residents and their families to determine residents’ views on the service being provided. An annual review of the quality and safety of care delivered to residents had not taken place at the time of the inspection, although the inspectors were shown the template that was to be used for this review.

Inspectors formed the view that the management systems in place were ineffective in that the auditing system, and the system of staff supervision and communication in place did not detect the serious deficiencies in the care being delivered particularly relating to the following:
- nutritional management of residents at risk of malnutrition as detailed under Outcome 11,
- basic hygiene needs of many residents not being met
- lack of appropriate supervision of residents at high risk of falls
- lack of staff knowledge and skill to assess and manage residents with behaviours that challenge.
- the staff replacement system was also not effective as detailed under Outcome 18,
- the poor level supervision of staff practice as detailed under Outcome 18,

Judgment:
Non Compliant - Major

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People).
People) Regulations 2013.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The only aspect of this outcome examined during the inspection related to the policy and procedures in place, and the documentation relating to the nutritional management of residents.

The inspector reviewed the policy in place on monitoring and documentation of nutritional intake in the centre, and found that it required updating to ensure that the nutritional management of residents identified as being at risk of malnutrition was comprehensive, with clearly identified protocols in place.

Food diaries were maintained for a number of residents but these were not always maintained contemporaneously, and did not consistently record the quantities of nutritional supplements consumed by residents or sufficient information regarding portion sizes to facilitate an approximate calculation of the nutritional intake of the residents over any given period of time.

Judgment:
Non Compliant - Moderate

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There was an adult protection policy in place within the centre and staff spoken to by the inspector confirmed that they had received training on elder abuse. However a recent physical assault of one resident by another resident had not been identified as abuse and was not investigated in line with the policy or notified to the Authority as an allegation of abuse. This incident had been notified as a serious injury to the resident.
This was discussed with the person in charge and the provider nominee and subsequently notified as an allegation of abuse to the authority. The inspectors were also concerned about the level of supervision within the centre due to staffing concerns as outlined under Outcome 18. The use of bedrails within the centre also required review.

Inspectors spoke with a number of residents during the course of the inspection and residents stated that they felt 'cared for' and 'looked after' within the centre. Staff were observed to be gentle and communicated well with residents getting down to the level of the seated resident and making eye contact, and pacing conversations appropriately. However at other times there was very little communication between staff and residents as staff focussed on completing the task.

Observation using QUIS (Quality interaction Schedule) was conducted for a 30 minute period during tea time in one unit. The inspector noted that apart from one period when a catering staff member set the table and did not speak to the residents who were seated at the table, all the interactions between residents and nurses or care staff were positive. There were three periods of positive care where staff focused on the task of eating the meal. Two periods of excellent care were observed when staff connected with the resident as a person and discussed their family or how a new resident was experiencing life in the centre.

Inspectors reviewed the files for a number of residents who had behaviours that challenge. Residents had all been reviewed by psychiatry of later life and any changes to prescribed medications were implemented. However there was no evidence that staff in the centre undertook a comprehensive assessment in order to develop a plan of care. Records of the hourly monitoring of these residents identified the location and mood of the resident but there was no documented evaluation of this information to inform a care plan or to guide practice. Care plans were generic and did not contain sufficient detail to guide care of the individual residents.

There was evidence that interventions had been beneficial for example a daily walk in the garden had led to a reduction of the number of incidents for one resident. Inspectors noted that the activity coordinator was responsible for taking the resident for a walk in the garden and the role of care staff in meeting the social needs of residents was minimal. Another resident who required on-going supervision could not be supervised at times when only two staff were on duty. This resident could be verbally or physically aggressive and posed a risk to the safety and wellbeing of residents. Staff who supervised residents in the day room were observed to be vigilant and observing residents rather than interacting or engaging with them. Records showed that the daily social activity for the majority of residents was watching television. Other entries included listening to music and walking around. Inspectors noted that a number of televisions were on various channels at volume high. This created a lot of noise and when coupled with the lack of stimulation and poor levels of social interaction between staff and residents, it did not create the optimal environment to support residents who had behaviours that challenge. Staff had attended training on dementia care and said that they had found the training beneficial and they now used distraction techniques and other strategies to prevent the escalation of behaviours that challenge.
The use of bedrails within the centre was reviewed by inspectors. The decision making assessment utilised within the centre was not reflective of current national guidance, and in many cases there was no documentation of alternative measures that were considered or trialled before the restrictive practice was implemented.

**Judgment:**
Non Compliant - Moderate

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**Outcome 08: Health and Safety and Risk Management**

The health and safety of residents, visitors and staff is promoted and protected.

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The centre had policies and procedures in place relating to health and safety. Staff had regular training in fire safety. However a number of staff spoken to by the inspector had no recollection of participation in a recent fire drill, and the documentation available for recent fire drills did not indicate any fire drills that simulated night time conditions within the centre. The inspectors also had concerns regarding infection control within the centre, and the management of risk relating to falls.

There was a safety statement in place that had been updated in September 2014. The centre had a risk management policy and risk assessment forms were completed for identified risks within the centre. Health and safety meetings were held in the centre, and there were systems in place to regularly check fire escape routes, fire alarm panels and emergency lighting. The centre had engaged an external provider to maintain and service the fire alarm, fire fighting equipment and the emergency lighting system and records of these were made available to the inspector. There was an emergency plan in place that provided guidance in the event of major incidents, although a number of staff had no specific knowledge of this plan.

The inspectors also identified deficiencies in the infection control systems in place within the centre, in that the laundry facilities were inadequate as outlined in Outcome 12, and staff knowledge was inconsistent regarding the use of cleaning products during the outbreak of an infectious disease. Inspectors followed up on notifications of an outbreak of norovirus (winter vomiting bug), which affected over 30 residents. Staff interviewed were not aware of current guidelines to increase routine cleaning to twice daily during an outbreak of norovirus. Hand hygiene audits were conducted within the centre and the most recent audit reported an overall compliance of 87%. Hand gels were provided throughout the centre. Inspectors observed that staff who attended various residents in communal rooms did not sanitise their hands when moving between residents. There was also variation in the standard of hand hygiene observed among nurses while administering medications. Excellent practice was evident in some units and poor
adherence to hand hygiene guidelines evidenced in another unit.

Risk management for falls also required review. Inspectors were informed that a colour coding system was in use to indicate residents at increased risk of falls. Inspectors observed that two residents at increased risk of falls had been accommodated in the new rooms in the extension to unit A, even though these rooms were over 50 metres from the nearest nurses station, and that on the first day of inspection there was no member of staff allocated to supervise this corridor as outlined in Outcome 18. Inspectors also observed other residents who had been assessed as being at an increased risk of falling having inadequate supervision to reduce this risk sufficiently.

Inspectors also found that the risk assessments in place for the use of bed-rails required review. A number of residents had non integrated bed rails in place, but the risk of entrapment had not been adequately assessed or measures put in place to check the safety of these bed-rails on a regular basis.

There was a system for internally reviewing incidents/adverse events involving residents, and the inspectors were informed that falls audits were also conducted to ensure appropriate referrals were made to the multi disciplinary team.

Judgment:
Non Compliant - Moderate

**Outcome 09: Medication Management**

*Each resident is protected by the designated centre’s policies and procedures for medication management.*

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
There were written operational policies implemented within the centre relating to the ordering, prescribing, storage and administration of medicines to residents. Inspectors were satisfied that the processes in place for handling and administration of medicines were safe, although inspectors were concerned that the medication rounds were taking up to three hours to complete on some units, with one of the identified reasons being interruptions to nursing staff and this is detailed under Outcome 18. The inspector also noted that certain aspect of transcribing and the documentation of prescribed medicines for crushing required review.

Medicines were supplied to the centre by a retail pharmacy business in a monitored dosage system that consisted of individual 'pouches' were appropriate. All medicines were stored securely within the centre, and fridges were available for all medicines or prescribed nutritional supplements that required refrigeration. All controlled (MDA) medicines were stored in a secure cabinet, and a register of these medicines was
maintained with the stock balances checked and signed for by two nurses each day.

The inspector observed medication administration and observed that nurses were knowledgeable regarding residents' individual medication requirements, and all medicines were seen to be administered in line with professional guidelines and best practice. However the inspector was concerned that there was the potential for prescribed medicines to be administered outside the prescribed timeframe due to the length of time taken to complete medication administration rounds. The inspector also reviewed a sample of medication prescription and administration sheets. Transcribed orders were being signed by the transcribing nurse, and by a second nurse but the date were not included as required by professional guidelines to indicate the date of transcribing. This finding is included under Outcome 11. The inspector also noted that crushing was not being indicated individually for each prescribed medicine by the prescriber on the prescription sheet.

There were procedures for documenting the administration of injections and antibiotics to residents to ensure the use of these medicines was effective and monitored appropriately, although there was no system in place to record the removal of transdermal patches that were applied for a prescribed number of hours each day.

The pharmacist was facilitated to meet all necessary obligations to residents in accordance with guidance issued by the Pharmaceutical Society of Ireland, and visited the centre on a regular basis.

Nurses had completed medication management training, and medication administration records were audited. Medication errors were recorded and reviewed within the centre, and a system to record and monitor near miss medication related incidents had also been recently implemented.

Judgment:
Non Compliant - Moderate

**Outcome 11: Health and Social Care Needs**

*Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.*

**Theme:**
Effective care and support

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
A number of the actions required from the previous inspection in November 2013 had not been fully addressed at the time of this inspection. These actions included a lack of meaningful activities for more dependent residents, and lack of review for some care plans based on changes to residents' assessed needs.

Inspectors found evidence of institutionalised practices and that the care and support provided to residents, especially those with dementia or those with high dependency needs did not reflect the assessed needs and wishes of the resident.

An immediate action plan was issued to the provider to ensure effective nutritional management for residents experiencing weight loss.

Residents had access to their own general practitioner (GP) and also to another GP who completed the four monthly reviews of residents within the centre. Fortnightly multi disciplinary team meetings with nurse, health care assistant, occupational therapy, and physiotherapy and psychology inputs were held to review recent hospital admissions, residents with deteriorating conditions and complex cases. Residents also had access to speech and language therapy, dietetic services and a tissue viability nurse on a referral basis.

Nursing assessments were undertaken. However, evidence-based nursing care was not consistently provided. Inspectors identified deficiencies in the nursing assessments, the development and implementation of care plans, lack of care plans to guide care in certain situations, and inadequate review of care plans in some instances. Inspectors also found that the basic hygiene needs of more dependent residents were not being met. There was limited documentation within the care plans to indicate the involvement of residents and or their representatives within the care planning process. There was no overview available within the care plans to indicate the overall clinical status of the residents.

The assessment and care planning process involved the use of validated tools to assess residents' risk of falls, nutritional status, level of cognitive impairment, skin integrity and dependency levels. The assessment to support residents' social, spiritual and emotional needs required significant improvement.

Care plans to address the assessed needs of residents were pre-printed and generic rather than person centered. They did not capture the unique needs and wishes of the resident. They also lacked the detail required to support the delivery of consistent evidenced-based nursing care. Care plan reviews were undertaken at least 4 monthly but the reviews were not sufficiently comprehensive.

Care plans developed to manage the risk of pressure ulcer development were not being implemented in a consistent manner, in that pressure relieving mattresses were set incorrectly, residents were not being repositioned at the recommended time intervals and the associated documents were not always correctly completed. Inspectors observed that two residents who were to be repositioned 2-3 hourly were sitting upright for up to 6 hours. A number of residents were observed by inspectors to be sitting in transit wheelchairs for considerable periods of time.
The care plans in place for a number of residents were not sufficient to manage their needs in the areas of falls management, nutritional management and behavioural management. Care plans for some residents at high risk of falls did not reference the level of supervision required or the use of alarm mats. During the course of the inspection the inspectors observed one resident who had been identified as being at a high risk of falls attempting to mobilise. There were no staff members supervising this resident and a staff member was requested to assist and supervise this resident due to concerns for his safety.

Inspectors identified 3 residents on one unit who were experiencing significant weight loss. The care plans in place to guide the nutritional management of these residents were not sufficiently detailed to effectively manage their needs, and the care plans in place had not been fully implemented. The recommendations of allied health care professionals were not consistently incorporated into all residents' care plans, and care plans were not always updated to reflect changes in residents' weights and identified risk of malnutrition. In another unit two residents had experienced weight loss in the preceding months but care staff were unaware of this and were not monitoring the food intake of these residents.

On the second day of inspection inspectors observed that the windows had been recently opened in the sitting room on one of the units but that the room was still uncomfortably warm. Jugs of juices and water were available and some residents filled their glasses and took additional fluids. The inspector noted that additional drinks were not offered to more dependent residents in the day room. Fluid charts were not always totalled and there was no evidence that they had been reviewed by a nurse.

Resident’s basic hygiene needs were not met. The assessments did not include information about each resident’s previous hygiene routines and rituals or preference for a bath or a shower. Care plans which were pre-printed, stated ‘Each resident to have a bath or a shower on request’. The benchmark for meeting hygiene needs was low. The nurse manager reported that they aimed to give each resident a bed bath or a shower once a week. When records for the residents in units A, B and C were examined, inspectors found that only three out of 84 residents had a shower twice in the week preceding the inspection and over 30 of residents who had a daily wash did not have a weekly bed bath or a shower.

A lack of meaningful activities for more dependent residents was an ongoing issue. Social events were organised which residents enjoyed. On the first day of inspection five residents visited the botanic gardens, and on the previous Sunday an orchestra and a car show had taken place within the grounds of the centre. The activity co-ordinator had a schedule of activities in place. However on a day to day basis the daily routine was determined by institutional care practices and staff who provided care did not prioritise meeting the social needs of residents. Inspectors found that residents in Unit B with the exception of four residents who asked not to be disturbed were awoken for their daily medications at 6am and five residents who had dementia were given their breakfast at 6.00am. Inspectors saw that these residents were also given their evening meal at 3.45 pm. These institutional practices was unacceptable and a breach of human rights of people with dementia. One resident had been bed bound for almost four months because she appeared to be uncomfortable in her chair. She had not been referred for a
seating assessment.

Transcribed orders were being signed by the transcribing nurse, and by a second nurse but the date was not included as required by professional guidelines to indicate the date of transcribing.

The personal and social care needs of residents were not comprehensively assessed. There was no evidence that staff undertook a comprehensive nursing assessment in order to develop a care plan to meet the unique personal social and emotional needs of the individual residents.

Care plans were generic and lacked specific details to guide care in order to meet the specific needs of the individual.

Residents' personal hygiene needs were not met to an acceptable standard.

**Judgment:**
Non Compliant - Major

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**Outcome 12: Safe and Suitable Premises**
The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Theme:**
Effective care and support

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
Building works had been completed at this centre since the last inspection with the addition of a number of en suite single rooms, communal rooms and the reconfiguration of other accommodation and communal rooms within the centre. One of the actions relating to twin rooms in one unit following the inspection conducted in November 2013 had not been addressed. Inspectors also found deficiencies relating to sluice rooms, and the maintenance of pressure relieving mattresses within the centre and the laundry facilities were inadequate.

Talbot Lodge Nursing Home is a single storey building that can accommodate up to 111 residents within four units referred to as 'A', 'B', 'C' and 'D'.

Unit A had been extended with the addition of 8 en suite bedrooms, a communal TV room with 5 chairs, sluice room, bathroom and storage. This extension comprised one
long corridor, with access to the rest of unit A via a locked set of doors. Unit A could accommodate 40 residents in total at the time of inspection. The new single en suite bedrooms were sufficiently spacious to ensure assistive equipment could be used when necessary. However inspectors did note that there were insufficient storage facilities provided in one of these bedrooms to enable the resident to store all their belongings appropriately. The majority of the rooms in Unit A provided accommodation for two residents (twin rooms). The larger twin rooms within this unit had previously provided accommodation for three residents, but at the time of inspection the layout of these rooms including the positions of the privacy curtain rails had not been rearranged to reflect the increased space available to the residents. Two large communal rooms had been added to Unit A since the last inspection providing a room for activities and or dining, and a sitting room. There was one nurses station/officer located in the original part of unit A. The inspectors noted that it was over 60 metres from this nurses office to the last bedroom in the new extension corridor via a locked set of doors.

Unit B had accommodation for 23 residents, and this included three twin rooms. Two of the twin rooms on this unit were not sufficiently large to meet the needs of the residents at the time of the inspection, and this had been highlighted in a previous inspection. There was no space for a locker beside one of the beds, and this bed was only accessible from one side as it was directly adjacent to the wall. There was limited circulation space within the room, and this space would be further compromised where residents using the rooms required additional mobility aids such as walking frames, rollators, transit or powered wheelchairs. The space available within these rooms was not sufficient to ensure the privacy and dignity of residents was maintained at all times. The third twin room was accommodating a couple at the time of the inspection, and the residents were satisfied with the layout and space available within the room. However the space available within this room would not be appropriate to accommodate two unrelated residents. There was a large communal sitting room and a dining room located in Unit B.

Unit C had accommodation for 27 residents, and also included some twin rooms and one four bedded bedroom. There were two small communal sitting areas available to residents within Unit C. There was no dining space available within this unit, although some residents were facilitated to dine in one of the dining rooms in the other units.

The laundry was also located in unit C. The layout and space available within the laundry was not adequate to ensure sufficient separation of clean and dirty laundry at all times. There was only one internal doorway through which all laundry had to pass, and there was no space to facilitate an appropriate flow system to prevent contamination of clean laundry and maintain infection control measures.

Unit D was a completely new unit that consisted of 21 en suite bedrooms, a large dining space and communal sitting rooms, including an activities room with facilities for residents to bake or do laundry. There was also a large outdoor patio area with chairs, tables and flower beds for use by residents.

There were sluice rooms located in each unit. Inspectors found that a number of the sluice rooms did not have sufficient racking for storage.
Additional facilities included the reception area with a large communal space with tea/coffee facilities for use by residents and visitors, oratory and a greenhouse for use by residents.

Inspectors noted that there were issues with a number of the pressure relieving mattresses in place for residents including, broken screens, broken alarm buttons, mattresses set at the incorrect setting, and no available maintenance records.

Maintenance work and painting was on going at the time of the inspection in some parts of the centre. The centre was visibly clean and suitable decorated. Many of the bedrooms viewed by inspectors had been personalised with photos, pictures and other personal items. There was a functioning call bell system in place throughout the centre.

**Judgment:**
Non Compliant - Major

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**Outcome 13: Complaints procedures**

The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
There was a written operational policy and procedure for the management of complaints. The person in charge was the nominated person to deal with all complaints and to ensure all complaints were fully investigated. The inspector examined the complaints records maintained within the centre and found that detailed records were kept of the complaint, actions taken, the outcome and the organisational learning from each complaint. It was clear from these records that complaints were addressed promptly and records of meetings held with the complainant were also maintained, that outlined actions agreed at these meetings and named a person responsible for completing the agreed actions. Complaints were also discussed at the management meetings within the centre. The complaints procedure was on display on one of the units, but the inspector noted that it was not on display prominently within all units at the time of inspection.

**Judgment:**
Compliant

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**Outcome 15: Food and Nutrition**

Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a
discrete and sensitive manner.

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Inspectors had serious concerns regarding the nutritional management of a number of residents who had experienced significant weight loss as outlined under Outcome 11. Inspectors also had concerns regarding the times at which some meals were provided to a number of residents as outlined in Outcome 11, and also regarding the temperature at which meals were being served to residents who ate in their bedrooms on one of the units.

The inspector reviewed the policy in place on monitoring and documentation of nutritional intake in the centre, and found that it required updating to ensure that the nutritional management of residents identified as being at risk of malnutrition was comprehensive, with clearly identified protocols in place. This is detailed under Outcome 5.

Inspectors observed residents dining in three of the dining areas within the centre. The dining rooms were pleasantly decorated and the use of brightly coloured crockery was suitable for people with dementia and residents who were visually impaired. Adequate staff were available to provide assistance to residents in the dining rooms. Staff sat with residents and paced the meal appropriately. They promoted independence by prompting residents to eat or by cutting up food so residents could eat independently. Menu options were available for all including those who require modified diet. Modified meals were attractively presented. Residents with whom inspectors spoke in the dining rooms were satisfied with the quantity and quality of the food provided.

The inspector also reviewed the menus and spoke with the catering manager, who outlined the systems in place to ensure effective communication between all staff to ensure that residents on specialised diets were catered for appropriately. The catering manager confirmed that the menus were reviewed for their nutritional content, and that residents were consulted regarding menu planning within the centre. However the menus were not reviewed by a dietician, even though this issue had been raised at previous inspections.

On unit C the majority of the residents on the second day of the inspection had their evening meal in their bedrooms, and the inspector noted that a number of the mince, moist meals were not sufficiently hot at the time of serving. These meals were sent back to the kitchen, but a number of these had to be sent back to the kitchen for a second time because the temperature of the food was still not suitable for serving. The number of staff available to assist residents with meals on unit C was also reduced as two health care assistants from this unit assisted in the dining room in unit D.
As discussed under Outcome 11 inspectors had concerns regarding the nutritional management of a number of the more vulnerable and dependent residents. The inspectors also noted that a number of residents who had experienced significant weight loss were not on fortified diets, although a number were on prescribed nutritional supplements. A number of staff spoken to by the inspectors were not knowledgeable of food fortification. Food diaries were maintained for a number of residents but these were not always maintained contemporaneously, and did not consistently record the quantities of nutritional supplements consumed by residents or sufficient information regarding portion sizes to facilitate an approximate calculation of the nutritional intake of the residents over any given period of time. This is detailed under Outcome 5.

Judgment:
Non Compliant - Moderate

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors had serious concerns regarding the staffing levels within the centre, and an immediate action plan was issued to the registered provider outlining the inspectors' concerns regarding the staff numbers and the supervision of staff in the centre.

Inspectors reviewed the staff rosters, and discussed the levels of staffing with the person in charge and the general manager. On the first day of the inspection two members of staff (one nurse and one health care assistant) were on sick leave and had not been replaced. The inspectors were informed that the centre did not employ agency staff and that the centre relied on staff members, not rostered for duty to cover sick leave. There was a text message system in place to check if staff could cover sick leave at short notice. Inspectors were also concerned about the level of staffing rostered to work at night within the centre, across all units but particularly related to unit A as there was only one nurse and one health care assistant rostered on this unit, and the layout of the unit, particularly the new eight bed extension, as discussed under Outcome 12 did not facilitate appropriate supervision level of the residents. The inspectors raised this concern on the first day of inspection and the person in charge agreed that one extra health care assistant would be rostered to work on unit A, on the new extension corridor.
at night time.

Night time staffing levels on unit B consisted of one nurse and one health care assistant, and the inspector observed that the nurse was interrupted 15 times while completing the medication administration round, and needed to assist the health care assistant with eight residents who required the assistance of two staff to go to bed.

Staffing levels within the centre were insufficient to ensure the timely delivery of care, and to ensure that residents' basic care needs including personal hygiene, nutritional management and repositioning were consistently met as outlined under Outcome 11. Staffing levels were also affecting the quality of life of residents who could not initiate conversation and required support to participate in activities. Insufficient staffing numbers also resulted in appropriate levels of supervision of residents, particularly of those residents who exhibited behaviours of concern/challenging behaviour or those residents who required support to mobilise to reduce their risk of falling. The staffing levels within the centre were dictating the daily routine for a number of residents in relation to their meal times as discussed in Outcome 11.

Inspectors were also concerned that staffing levels and skills mix within the centre were resulting in staff not being supervised appropriate to their role. The clinical nurse managers were responsible for supervising all nursing staff, health care assistants and cleaning staff. The clinical nurse managers also had responsibility for finding replacement staffing for sick leave, in addition to their other responsibilities. Nurses spent long periods administering medications and had limited availability to direct care or to supervise the care delivered to residents by health care staff.

There were policies and procedures in place for staff recruitment. There were no volunteers working in the centre at the time of the inspection. The inspector reviewed a number of staff files and found that they met the requirements of Schedule 2 of the regulations.

Records were kept of staff training and mandatory training included manual handling, fire safety, elder abuse, health and safety, food safety (including allergens), and dysphagia and feeding. Staff also received training in wound care, falls prevention, dementia care, CPR, and nursing staff received regular medication management training. There was a system of staff appraisal in place that consisted of annual performance development plans. Inspectors witnessed good manual handling practices throughout the inspection.

**Judgment:**
Non Compliant - Major
Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Jim Kee
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Talbot Lodge Nursing Home</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000182</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>02/07/2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>18/08/2015</td>
</tr>
</tbody>
</table>

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Statement of Purpose

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose describes the services provided but lacked sufficient detail in some areas as outlined in the report.

Action Required:
Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Residents in Designated Centres for Older People) Regulations 2013.

Please state the actions you have taken or are planning to take:
The statement of purpose will be revised to include all the information as specified in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People)

Proposed Timescale: 30/09/2015

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre was insufficiently resourced in terms of staff numbers and appropriate skills mix to ensure effective delivery of care to residents.

Action Required:
Under Regulation 23(a) you are required to:

Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
1. An additional staff member has been rostered on night duty shift in Area A with effect from 02/07/15 pending a review of staff allocations.
2. A comprehensive review of staff allocations based on dependency levels/assessed needs of residents, bed numbers and rosters will be completed by 31/07/15. This review will consider if the impact of the increase in bed numbers and changing needs of residents are adequately provided for in the numbers employed.
3. A staff allocations index which will contribute to the decision making process on staff allocations based on the dependency level/assessed needs of residents will be finalised by 31/07/15. The index will be used to ensure that the assessed needs of residents are reflected in how staff are allocated.
4. On completion of the statistical analysis associated with actions (2) and (3) above, the issues of staffing levels, skill mix, supervision, work practices, experience, roster scheduling will be externally reviewed and reported on. This will be completed by 21/08/15. This review will also look at the impact on staffing of factors arising from the design/layout of the centre. Any recommendations arising from the review will be carefully considered and an action plan to give effect to the recommendations will be developed.

As contingency cover for unforeseen absences, with effect from 09/07/15 an additional member of staff is rostered on day duty for up to 12 hours if required pending completion of numbers (2), (3) and (4) above. This arrangement will remain in place until 30/09/15. Presently the extra additional rostered staff member is a Health Care Assistant or a pre-registered Nurse. It can also be a staff nurse pending nursing
availability. ‘If required’ relates to the duration of the shift the staff member is required to cover. Not all shifts are 12 hours long and the approval is in place to cover up to 12 hours. The requirement is automatic for the duration of the shift that is vacant.

A computerised Time Management System has been purchased and will be implemented before the 31/08/15. This system will give real time information in relation to staffing levels on duty at any given time. It will also improve management oversight and facilitate early implementation of appropriate measures in response to unforeseen absences. The management information available from the system will be used to keep under constant review the effectiveness of systems in place to have full complements of staff at work at all times. Immediately on coming on duty managers will be able to verify staffing levels and initiate contingency arrangements if necessary to achieve full staffing complement. It will also provide quality management information in relation to absences which will allow management to identify and analyse trends, establish contributing factors that give rise to absences and thereafter put measures in place to reduce the overall level of absence. With the introduction of the new Time Management System the existing roster documentation will be reviewed with a view to making it more user friendly.

To increase our relief cover capacity for unforeseen absences we are currently recruiting additional part time and temporary staff. In this regard we have advertised on 17th July 2015 for nursing staff and earlier in July for Health Care Assistants. Recruitment of suitably qualified and experienced staff is an on-going process. Currently we have 3 nurses undertaking an adaptation programme, 1 additional nurse will commence adaptation on 10/08/15 and 2 nurses scheduled for an adaptation programme in autumn 2015.

With effect from 13/07/15, staffing allocations and replacement levels will be a standing item on the Management Team agenda in the future. It will also be on the agenda for Performance Management meetings with the relevant operational managers.

To improve the skill mix and to ensure the effective delivery of care an additional allocation of 96 nursing hours per week has been approved. In addition an increase of 84 hours per week in the allocation of HCA hours for day duty has been sanctioned. Recruitment to fill these hours has commenced. Subject to the current availability of staff and the success of the recruitment processes currently underway these additional hours are being implemented with immediate effect.

Pending the outcome of the recruitment process for nursing staff a contract has been signed with a Nursing Agency to supply staff when available.

Proposed Timescale: 01/10/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management systems in place were ineffective in that the auditing system, and the system of staff supervision and communication in place did not detect the serious deficiencies in the care being delivered.

Action Required:
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**
There is a very comprehensive audit programme in place for both care and management elements of the service. The service is monitored by measurement of Key Performance Indicators. The quality audit programme will now be extended to include additional care elements identified during the inspection.

To ensure consistent and effective levels of clinical supervision are in place, clinical management structures are being enhanced as follows.

Appointment of a Clinical Services Manager. This is a very senior appointment to lead the clinical team. The person appointed will also act as Provider Nominee and Person In-Charge and will be required to address all of the issues highlighted in the report in the most recent inspection.

The Clinical Services Manager will be supported by two senior nurse managers who will be assigned to supervision of staff and service provision to residents. They will also be required to carry out administrative and operational duties that will facilitate the CNM’s and nursing staff to concentrate on direct care to residents and supervision of HCA’s.

**Proposed Timescale:** 01/10/2015

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The provider did not undertake an annual review of the quality and safety of care delivered to residents in the centre.

**Action Required:**
Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

**Please state the actions you have taken or are planning to take:**
A comprehensive audit tool was purchased on 16/06/15 to carry out the annual review of quality. The audit tool template was shown to the inspectors during the course of the inspection. The inspection team confirmed the tool was comprehensive. On the 16/06/15 two senior members of staff were assigned to carry out the annual review of quality on an unannounced basis.

**Proposed Timescale:** 30/09/2015
<table>
<thead>
<tr>
<th>Outcome 05: Documentation to be kept at a designated centre</th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Governance, Leadership and Management</td>
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<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>The inspector reviewed the policy in place on monitoring and documentation of nutritional intake in the centre, and found that it required updating to ensure that the nutritional management of residents identified as being at risk of malnutrition was comprehensive, with clearly identified protocols in place.</td>
</tr>
<tr>
<td><strong>Action Required:</strong> Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong> Food and fluid balance chart has been revised to facilitate the recording of additional relevant information including nurse instruction specific to the resident’s nutritional requirements, food type, portion sizes, supplements, food fortification and fluid grade. 24 hour food and fluid charts are totalled and checked by nursing staff. For on-going monitoring purposes the daily fluid intake is documented on a monthly chart specific to each resident. The policy on nutritional management of residents identified as being at risk of malnutrition is under review and will be completed by 30/09/15. The standard operating procedures in place to support the policy will also be reviewed at this time.</td>
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<tr>
<td>Food diaries were maintained for a number of residents but these were not always maintained contemporaneously, and did not consistently record the quantities of nutritional supplements consumed by residents or sufficient information regarding portion sizes to facilitate an approximate calculation of the nutritional intake of the residents over any given period of time.</td>
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<tr>
<td><strong>Action Required:</strong> Under Regulation 21(1) you are required to: 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.</td>
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<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
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</table>
All staff are advised that all food including supplements, fluid intake and specific details of portion sizes must be accurately and contemporaneously recorded in the resident’s records. This will be supervised by the Nursing staff and monitored by the PIC and completed by 31/07/15. Food and fluid balance record sheet has been revised to facilitate the recording of additional relevant information including portion sizes and supplements.

The importance of nutrition, fluid intake and accurate record keeping is included in the induction programme provided to all staff. Refresher training will be prioritised and provided by the PIC by 31/08/15.

With immediate effect and until further notice the monthly audit and monitoring report on the nutritional status of residents will be on the agenda for Management Team meetings.

**Proposed Timescale:** 31/08/2015

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**Outcome 07: Safeguarding and Safety**

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The use of bed-rails was not in line with the national policy.

**Action Required:**
Under Regulation 07(3) you are required to: 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.

**Please state the actions you have taken or are planning to take:**
A full review of the use of bed rails commenced in May 2015 and was completed on 19/07/15. The review involved a critical review of each incidence of use of bed rails to determine compliance with policy. The outcome resulted in a significant reduction in the use of bed rails. A more robust review system of bed rail use is now in place supported by regular audits.

The supporting policy and MDT clinical decision prescription process are currently being revised to ensure compliance with national policy and that the following are adequately provided for – commitment to least restrictive practice for shortest length of time, authorisation process, special precautions, risk of entrapment, consent, monitoring, review, audit, emergency use and duty of care.

**Proposed Timescale:** 30/09/2015

**Theme:**
Safe care and support
**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The decision making assessment for the use of bed-rails was not reflective of current national guidance, and in many cases there was no documentation of alternative measures that were considered or trialled before bed rails were used.

**Action Required:**
Under Regulation 07(3) you are required to: 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.

**Please state the actions you have taken or are planning to take:**
The policy and MDT clinical decision prescription process are currently being revised to ensure compliance with national policy and that the following are adequately provided for – commitment to least restrictive practice for shortest length of time, authorisation process, special precautions, risk of entrapment, consent, monitoring, review, audit, emergency use and duty of care

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<th>Proposed Timescale: 30/09/2015</th>
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**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no evidence that staff undertook a comprehensive assessment of residents who had behaviours that challenged in order to develop a plan of care. There was no evaluation of the hourly monitoring records of these residents to inform a care plan.

**Action Required:**
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

**Please state the actions you have taken or are planning to take:**
Currently there are 16 nursing assessments carried out for residents. While a number of these assessments cover care issues that would indicate behaviours that challenge, none are specifically designed for that purpose. However there is a Behavioural Assessment Record maintained to inform the care plan. In future a specific assessment of residents who have behaviours that challenge will be carried out in order to inform the plan of care developed. To ensure the assessment is appropriate, professional advice is currently being sought. The current care plan in place for behaviours that challenge is categorised under “Mental Health Issues” this care plan will also be reviewed at this time.

From January 2014 to-date 19 nurses and 35 health Care Assistants have received training in Dementia Care/Challenging Behaviour. This training will continue to be delivered on a regular basis.

In future in the case of new applications for admission from home, the applicants
General Practitioner will be requested to complete a referral form that asks specific questions in relation to behaviours. If this information is not readily available in respect of admissions from other services it will be requested in advance of admission.

**Proposed Timescale:** 30/09/2015

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

A resident who presented a risk to the safety and welfare of other residents and required on-going supervision was unsupervised at times when only two staff were on duty.

**Action Required:**

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

**Please state the actions you have taken or are planning to take:**

The existing complement of staff for day and night duty combined is 36. A review of the location and supervision arrangements of residents who require on-going supervision will be carried out to determine the most appropriate arrangements for their management which will guard against any potential that exists for adverse interaction between residents. In this regard an area will be designated and staffed appropriately for residents who present a risk to the safety and welfare of others. Timescale 30/09/15.

A comprehensive review of staff allocations based on dependency levels/assessed needs of residents, bed numbers and rosters will be completed by 31/07/15. Separately the issue of staffing levels is part of an external review which will be completed by 21/08/15.

To improve the skill mix and to ensure the effective delivery of care an additional allocation of 96 nursing hours per week has been approved. In addition an increase of 84 hours per week in the allocation of HCA hours for day duty has been sanctioned. Recruitment to fill these hours has commenced. Subject to the current availability of staff and the success of the recruitment processes currently underway these additional hours are being implemented with immediate effect.

Pending the outcome of the recruitment process for nursing staff a contract has been signed with a Nursing Agency to supply staff when available.

To ensure consistent and effective levels of clinical supervision are in place, clinical management structures are being enhanced by the appointment of a Clinical Services Manager. This is a very senior appointment to lead the clinical team. The person appointed will also act as Provider Nominee and Person In-Charge and will be required to address all of the issues highlighted in the report in the most recent inspection. The Clinical Services Manager will be supported by two senior nurse managers who will be assigned to supervision of staff and service provision to residents. They will also be required to carry out administrative and operational duties that will facilitate the CNM’s and nursing staff to concentrate on direct care to residents and supervision of HCA’s.
**Proposed Timescale:** 01/10/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A recent physical assault of one resident by another resident had not been identified as abuse, had not been investigated in line with the policy and was not notified to the Authority as an allegation of abuse.

**Action Required:**
Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.

**Please state the actions you have taken or are planning to take:**
This incident was notified to HIQA (NF03) as a serious injury to a resident. The incident was internally reviewed in line with our policy of reviewing all incidents to determine contributing factors, put control measures in place to minimise a reoccurrence and to disseminate the learning from the review to staff. During the course of the inspection the incident was reclassified and notified again to HIQA (NF06). Terms of reference for investigation of the incident and investigation team are in place. In line with policy the investigation commenced on 16th July 2015 and was completed on 7th August 2015. HIQA. On completion of the investigation a report was submitted to HIQA.

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**Proposed Timescale:** 18/08/2015

**Outcome 08: Health and Safety and Risk Management**

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Residents at risk of falls were not adequately supervised.
Two residents at risk of falls were accommodated in rooms which were over 50 metres from the nearest nurses’ station.

**Action Required:**
Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

**Please state the actions you have taken or are planning to take:**
Falls are audited on a monthly basis to identify trends and contributing factors. Depending on the audit outcome the results may be discussed at the fortnightly multidisciplinary team meeting. All falls are internally reviewed and any learning from
the outcome of the reviews is disseminated to the staff to improve staff awareness. In relation to the case of the two residents highlighted in the report in the new 8 bed extension in Area A an additional member of staff for day duty was approved and allocated to specifically supervise the residents in this area when the beds opened. On the day of the inspection due to an unforeseen absence of a member of staff there was no staff member specifically assigned to this area and supervision was provided by the other staff assigned to Area A. In an effort to prevent this happening again an additional member of staff is now rostered on day duty to cover for an unforeseen absence. This arrangement will remain in place until 30/09/15. Presently the extra additional rostered staff member is a Health Care Assistant or a pre-registered Nurse. It can also be a staff nurse pending nursing availability. An additional member of staff is also now rostered on night duty in this area.

The risk management policy set out in Schedule 5 will be reviewed to ensure that the measures and actions in place are appropriate to control the risk identified.

A review of the location and supervision arrangements of residents who require on-going supervision due to risk of falling will be carried out to determine the most appropriate arrangements for their management. In this regard an area will be designated and staffed appropriately for residents who present with a high risk of falling.

**Proposed Timescale:** 30/09/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A number of residents had non integrated bed rails in place but the risk of entrapment had not been adequately assessed or measures put in place to check the safety of these bed-rails on a regular basis.

**Action Required:**
Under Regulation 26(1)(c)(iii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.

**Please state the actions you have taken or are planning to take:**
A full review of the use of bed rails commenced in May 2015 and was completed on 19/07/15. The review involved a critical review of each incidence of use of bed rails to determine compliance with policy. The outcome resulted in a significant reduction in the use of bed rails. A more robust review system of bed rail use is now in place supported by regular audits.

The supporting policy and MDT clinical decision prescription process are currently being revised to ensure compliance with national policy and that the following are adequately provided for – commitment to least restrictive practice for shortest length of time, authorisation process, special precautions, risk of entrapment, consent, monitoring, review, audit, emergency use and duty of care.

The risk management policy set out in Schedule 5 will be reviewed to ensure that the measures and actions in place are appropriate to control accidental injury.
Proposed Timescale: 30/09/2015  
Theme: Safe care and support  

The Registered Provider is failing to comply with a regulatory requirement in the following respect: 
The inspectors identified deficiencies in the infection control systems in place within the centre,  
- there was variation in the standard of hand hygiene practices across the centre.  
- Staffs' knowledge was inconsistent regarding the use of cleaning products during the outbreak of an infectious disease.  
- Staff were also not aware of current guidelines to increase routine cleaning to twice daily during an outbreak of norovirus. 

Action Required:  
Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff. 

Please state the actions you have taken or are planning to take:  
To improve infection control practices a number of clinical sinks have been fitted and hand hygiene posters are strategically placed beside sinks throughout the Nursing home. In February 2015 a Clinical Nurse Manager completed an accredited course in Infection Control with the College of Surgeons. Hand hygiene is also part of the Medication Administration audits which are also conducted on a weekly basis. In an effort to standardise best practice the results of the on-going audits will be carefully monitored to identify staff training requirements which will be provided.  
During an outbreak of an infectious disease, advice is sought from HSE Public Health and Microbiology teams in how to deal with the outbreak. Regular conference calls continue for the duration of the outbreak and until such time as the outbreak is declared to be over and cleared. The advice received from the HSE teams is implemented in full. 
Further training will be provided for staff so as to ensure that the procedures used by staff to deal with an outbreak are consistent with the standards for the prevention and control of healthcare associated infections and that they have adequate knowledge on the use of the cleaning products during an outbreak of an infectious disease. Hygiene audits are conducted twice a year by an external Infection Control Nurse Specialist. To maintain the progress achieved to-date these audits will be continued. 

Proposed Timescale: 30/09/2015  
Theme: Safe care and support  

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Documentation for recent fire drills did not indicate any fire drills that simulated night time conditions within the centre.

**Action Required:**
Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

**Please state the actions you have taken or are planning to take:**
Fire training is mandatory. Fire drills are initiated on an unannounced basis at regular intervals and after a number of new staff commence work. Fire drills are intended as a practical training opportunity and experience for new staff. The exact time of Fire Drills will be documented in future.

Fire training records confirm the following. In 2014, 89 staff attended fire training and 64 attended fire drills. To-date in 2015, 50 staff attended fire training and 26 attended fire drills. Fire drills for the benefit of night staff were held on 22/01/15 and 28/07/15. A further two drills will be held before 31/08/15.

**Proposed Timescale:** 31/08/2015

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**Outcome 09: Medication Management**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

There was the potential for prescribed medicines to be administered outside the prescribed timeframe due to the length of time taken to complete medication administration rounds.

Crushing was not being indicated individually for each prescribed medicine by the prescriber on the prescription sheet.

There was no system in place to record the removal of transdermal patches that were applied for a prescribed number of hours each day.

**Action Required:**
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident’s pharmacist regarding the appropriate use of the product.

**Please state the actions you have taken or are planning to take:**
To reduce the number of interruptions during medication rounds and facilitate administration of medications within the prescribed timeframe, nursing staff now wear
jackets “do not disturb – nurse on medication round” and an additional drug trolley will be put into operation by 01/09/15
The allocation of an additional 96 nursing hours per week will address the issue of interruptions during medication rounds in that there will be additional nursing staff available to allow protected time for medication rounds.
To ensure compliance with professional guidelines, drug prescription records for all residents will be reviewed to ensure crushing of medication is documented against each individual medication prescribed.
A system for recording the removal of transdermal patches has been implemented. This includes recording of date, time and signature.

Proposed Timescale: 01/10/2015

Outcome 11: Health and Social Care Needs
Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plan reviews were not sufficiently comprehensive.

Action Required:
Under Regulation 05(5) you are required to: Make the care plan, or revised care plan, prepared under Regulation 5 available to the resident concerned and, with the consent of that resident or where the person-in-charge considers it appropriate, to his or her family.

Please state the actions you have taken or are planning to take:
All care plans will be reviewed with residents. Families will be consulted as part of the review process. The revised care plan will be made available to the resident and with the consent of the resident or where the Person-In-Charge considers it appropriate to his or her family. In future all consultation with the resident and family in relation to care plan reviews will be clearly documented, dated and signed in the residents chart. The review of all care plans will be prioritised based on resident dependency levels. Following the above review, all care plans will be reviewed on a quarterly basis and more frequently if necessary. The identification of a new care issue will also trigger a care plan review and the plan will document the following in relation to the management of care issues–
1. Identification of care issue
2. Setting a goal
3. Implementation of intervention
4. Monitoring of progress
5. Review as necessary
6. Overall assessment of resident
7. Incorporate additional recommendations
The care triggers identified in the care plan document are designed to ensure that important care issues are not overlooked when assessing residents. Before commencing
the review of all care plans the existing care plan documentation will be reviewed in light of the issues raised in the inspection report. The review will also look at samples of care plan documentation in use in other centres.

Proposed Timescale: 30/11/2015

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Care plans developed to manage the risk of pressure ulcer development were not being implemented in a consistent manner,
- that pressure relieving mattresses were set incorrectly,
- residents were not being repositioned at the recommended time intervals
- A number of residents were left sitting in transit wheelchairs for considerable periods of time.

Care plans for some residents at high risk of falls did not reference the level of supervision required or the use of alarm mats.

The care plans in place to guide the nutritional management of these residents were not sufficiently detailed to effectively manage their needs, and the care plans in place had not been fully implemented.

Residents' personal hygiene needs were not met to an acceptable standard.

Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:
Managing the Risk of Pressure Areas
Pressure Relieving Mattresses - A review of all pressure relieving mattresses is underway. All mattresses will be catalogued and asset numbered for future reference and maintenance records. All repairs required will be carried out and current maintenance/service records will be updated and maintained for all mattresses. The repairs will include the calibration of all units to ensure they are working effectively and settings are legible. Timescale 30/09/15.
Since the inspection took place five new pressure relieving mattresses are now in place.
Repositioning of Residents - Current practice in relation to the repositioning of residents will be reviewed to ensure that where care plans provide for repositioning of residents that the residents are repositioned at all times whether the resident is in or out of bed. A revised “repositioning chart” will be implemented to record practice.
Use of Transit Wheelchairs - An immediate review of the use of transit wheelchairs for purposes other than transporting/transferring residents will be carried out with a view to minimising the amount of time residents spend sitting in them.
Residents at Risk of Falls - Falls are audited on a monthly basis to identify trends and
contributing factors. Depending on the audit outcome the results may be discussed at the fortnightly multidisciplinary team meeting. All falls are internally reviewed and any learning from the outcome of the reviews is disseminated to the staff to improve staff awareness.

Care plans for all residents at high risk of falls will be reviewed to ensure that the level of supervision required is clearly documented together with details of control measures in place, to include – hip protectors and mat, bed and chair alarms.

A review of the location and supervision arrangements of residents who require on-going supervision due to risk of falling will be carried out to determine the most appropriate arrangements for their management. In this regard an area will be designated and staffed appropriately for residents who present with a high risk of falling. Timescale 30/09/15.

Nutritional Management - The current nutritional risk status of each resident has been reviewed by the Clinical Nurse Manager in each unit. The Malnutrition Universal Scoring Tool (MUST) and Body Mass Index (BMI) were used to conduct the review. All residents with a MUST score of 2 were notified to their GP during the week commencing 13/07/15 and GP advice was noted and implemented. Residents with a MUST score of 2 are weighed weekly and monitored on a daily basis for fluid and food intake.

All residents who are identified as at risk will be immediately referred for a comprehensive assessment by GP and PIC. This includes a review of observation and monitoring records of BMI and MUST scores. It also includes food and fluid intake monitoring records. Based on the outcome of the assessment a revised care plan will be prepared in consultation with the resident and where appropriate the resident’s family by 31/07/15.

Care plans will be audited by review and on-going monitoring of MUST and BMI scores, weights, food and fluid intake. Any indicators of increasing risk will result in a referral to GP for review and advice. This process will be overseen by the PIC.

The services of a suitably qualified health care professional (Dietician) in nutritional needs will be engaged by Talbot Lodge Nursing Home. This service will include consultations, diet reviews, and calorie and nutrient analysis of menus. In this regard the service is scheduled to commence on 21st August 2015.

Monthly audits and monitoring of resident’s weights and nutritional status will be implemented with immediate effect. Weekly monitoring will apply in respect of residents identified as being at risk. The next audit will be completed by 14/08/15 and will be overseen by the PIC.

All staff are advised that all food including supplements, fluid intake and specific details of portion sizes must be accurately and contemporaneously recorded in the resident’s records. This will be supervised by the Nursing staff and monitored by the PIC and completed by 31/07/15.

The importance of nutrition, fluid intake and accurate record keeping is included in the induction programme provided to all staff. Refresher training will be prioritised and provided by 31/08/15.

Food and fluid balance record sheet has been revised to facilitate the recording of additional relevant information including portion sizes and supplements.

With immediate effect and until further notice the monthly audit and monitoring report on the nutritional status of residents will be on the agenda for Management Team meetings.

Personal Hygiene Needs - In relation to residents personal hygiene needs all residents are offered the choice of shower, bath, full bed bath or full body wash. Personal
hygiene needs are attended to on a daily basis or more frequently if required. On review of the issues raised in the inspection report it has been identified that some staff are not clearly documenting the extent of how residents’ personal hygiene needs are cared for. This is attributable to inappropriate use of abbreviated descriptions of the care provided, in that some staff, regardless of how the personal hygiene needs are met document “wash” which does not accurately reflect the care provided in many cases.

Personal hygiene audits conducted on 06/07/15 and repeated on 26/07/15 indicate that all residents who are not independent for personal hygiene needs receive assistance with a full body wash, full bed bath or shower on a daily basis.

In future residents’ wishes in relation to how they wish to be cared for when it comes to personal hygiene needs and the full extent of how these needs are met will be clearly documented.

**Proposed Timescale:** 30/09/2015

**Theme:**  
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The recommendations of allied healthcare professionals were not consistently incorporated into all residents' care plans, and care plans were not always updated to reflect changes in residents weights and identified risk of malnutrition.

**Action Required:**  
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident’s family.

**Please state the actions you have taken or are planning to take:**  
The current nutritional risk status of each resident has been reviewed by the Clinical Nurse Manager in each unit. The Malnutrition Universal Scoring Tool (MUST) and Body Mass Index (BMI) were used to conduct the review. All residents with a MUST score of 2 were notified to their GP during the week commencing 13/07/15 and GP advice was noted and implemented. Residents with a MUST score of 2 are weighed weekly and monitored on a daily basis for fluid and food intake.

All residents who are identified as at risk will be immediately referred for a comprehensive assessment by GP and PIC. This includes a review of observation and monitoring records of BMI and MUST scores. It also includes food and fluid intake monitoring records. Based on the outcome of the assessment a revised care plan will be prepared in consultation with the resident and where appropriate the resident’s family by 31/07/15.

Care plans will be audited by review and on-going monitoring of MUST and BMI scores, weights, food and fluid intake. Any indicators of increasing risk will result in a referral to GP for review and advice. This process will be overseen by the PIC.

The services of a suitably qualified health care professional (Dietician) in nutritional
needs will be engaged by Talbot Lodge Nursing Home. This service will include consultations, diet reviews, and calorie and nutrient analysis of menus. In this regard the service is scheduled to commence on 21st August 2015. The recommendations of the dietician will be incorporated into the care plan and the dietician will be required to record details of consultations and advice in the residents chart.

Monthly audits and monitoring of resident’s weights and nutritional status will be implemented with immediate effect. Weekly monitoring will apply in respect of residents identified as being at risk. The next audit will be completed by 31/08/15 and will be overseen by the PIC.

**Proposed Timescale:** 31/08/2015

**Theme:**
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The personal and social care needs of residents were not comprehensively assessed. There was no evidence that staff undertook a comprehensive nursing assessment in order to develop a care plan to meet the unique personal social and emotional needs of the individual residents.

**Action Required:**
Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person’s admission to the designated centre.

**Please state the actions you have taken or are planning to take:**
As part of the recent expansion of facilities in the nursing home two additional dedicated rooms for activities have been provided. Activities provided include the following -

- Weekly bus tours to locations of residents choice.
- Fit for Life,
- Imagination GYM,
- Arts & Crafts,
- Baking,
- Live Music,
- Beauty Therapy,
- Sonas Therapy,
- Reminiscence Therapy,
- Variety of Games,
- Book Club, Movies,
- Bingo,
- Horticulture
- Pastoral Care Services.
The activities are co-ordinated by the Activities Co-ordinator who also delivers one to one sessions for residents not able or interested, in group activities.

The recently implemented new residents chart contains a section on Quality of Life. This section of the chart was designed to meet the personal and social needs of residents and has provision to contain the following –

- Resident Personal Profile
- Social and Personal Activity Plan
- Resident and Family Meetings
- Advocacy Notes
- Other Social Activity Notes

In May 2015, social and personal activity plan data was collected in respect of all residents. For all new admissions the Resident Personal Profile, and Social and Personal Activity Plan documents are completed on admission. The information received will be used to develop a care plan to meet the personal and social care needs of residents. The care plans will be unique to each individual resident and details of how residents personal and social care needs are provided for will in future be clearly documented.

To enable the development of an effective care plan, information is obtained through the completion of the Resident Personal Profile document on memories and interests from childhood, adolescent and adulthood. In addition the Social Personal and Activity Plan gathers information on the Personal Profile of the resident and their current interests in participating in individual or group activities across a range of activity areas including physical activities, crafts, musical entertainment, day tours, outdoor activities, games and competitions. Residents are also invited to put forward suggestions in relation to activities of interest to them.

**Proposed Timescale:** 31/10/2015

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Care plans were generic and lacked specific details to guide care in order to meet the specific needs of the individual.

**Action Required:**
Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident’s admission to the designated centre.

**Please state the actions you have taken or are planning to take:**
The care triggers identified in the care plan document are designed to ensure that important care issues are not overlooked when assessing residents. In light of the issues raised in the inspection report the existing care plan documentation will now be
reviewed. The purpose of the review will be to ensure that the template in use, allows for the recording of specific details to guide care in order to meet the specific needs of the individual. The review will also look at samples of care plan documentation in use in other centres and the training needs of staff in the preparation of quality care plans based on the assessment of residents.

**Proposed Timescale:** 31/10/2015

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A resident who was bed bound for 4 months because she was uncomfortable when seated had not been referred for a seating assessment.

**Action Required:**
Under Regulation 06(2)(c) you are required to:

*Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.*

**Please state the actions you have taken or are planning to take:**
Physiotherapy and Occupational Therapy are provided by the Nursing Home for residents. All residents can access both services as required. On occasions for palliative care and comfort reasons, following nursing assessment, residents can be nursed in bed for extended periods. A multidisciplinary team review of residents currently nursed in bed will take place and referrals as considered appropriate will be made.

**Proposed Timescale:** 18/08/2015

**Outcome 12: Safe and Suitable Premises**

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were insufficient storage facilities provided in one of the bedrooms on the extension to unit A to enable the resident to store all their belongings appropriately.

**Action Required:**
Under Regulation 17(2) you are required to:

*Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.*

**Please state the actions you have taken or are planning to take:**
This bedroom is one of 29 new bedrooms built and furnished to the highest standards
and in full compliance with HIQA requirements. In this particular case staff have been supporting the resident to manage the volume of personal property in a manner consistent with living in a nursing home. However the resident likes to visit home frequently and rotate personal property between home and nursing home. The visits home are a feature of this residents routine and the resident will continue to be encouraged to maintain this routine while at the same time manage the volume of personal property retained in the nursing home. In a further attempt to support the resident to manage personal property, additional bedroom furniture will be provided for the resident concerned by 31/08/15.

**Proposed Timescale:** 31/08/2015  
**Theme:** Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The larger twin rooms within unit A had previously provided accommodation for three residents, but at the time of inspection the layout of these rooms including the positions of the privacy curtain rails had not been rearranged to reflect the increased space available to the residents.

**Action Required:**  
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

**Please state the actions you have taken or are planning to take:**  
As part of a substantial upgrade of existing accommodation and to achieve full compliance with the regulations the bedrooms concerned were recently converted from three bed to two bed. In each case the additional space available is identified for use as a general living area for the benefit of the residents by the provision of armchairs and a coffee table. It will also facilitate residents to entertain visitors in the privacy of their own room. The current position of the privacy curtain rails allows the space to be used by both residents for the purpose identified. The furniture will be in place by 31/08/15.

**Proposed Timescale:** 31/08/2015  
**Theme:** Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Two of the twin rooms on unit B were not sufficiently large to meet the needs of the residents as detailed in the report. The third twin room was accommodating a couple at the time of the inspection, and the residents were satisfied with the layout and space available within the room. However the space available within this room would not be
appropriate to accommodate two unrelated residents.

**Action Required:**
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

**Please state the actions you have taken or are planning to take:**
The occupancy, use and layout of these rooms have been reviewed and the two twin rooms on unit B will be converted to single use. Timescale 30/09/15.
The third twin room will also be converted to single use when the current occupancy arrangements change.
These changes will ensure that the privacy and dignity of residents is met, that suitable furniture can be made available to residents and that the position of the bed will facilitate the use of assistive equipment when needed.

**Proposed Timescale:** 30/09/2015

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The layout and space available within the laundry was not adequate to ensure sufficient separation of clean and dirty laundry at all times. There was only one internal doorway through which all laundry had to pass, and there was no space to facilitate an appropriate flow system to prevent contamination of clean laundry and maintain infection control measures.

**Action Required:**
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

**Please state the actions you have taken or are planning to take:**
Arrangements are in place for an Infection Control Nurse Specialist to visit the laundry on 18/08/15 and advise on the requirements in relation to achieving a work flow that provides adequate separation between clean and dirty laundry. Timescale 18/08/15
Advice is also being requested on interim measures that will improve the current arrangements. In this regard alternative storage arrangements for clean laundry are under consideration. Timescale 31/10/15.
On receipt of the advice an action plan will be developed to give effect to the changes required to comply with recommended best practice.
If the decision is to decommissioning the existing laundry and moving off-site the timescale for completion will be 31/01/16.
Proposed Timescale: 31/01/2016

Theme: Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors found that a number of the sluice rooms did not have sufficient racking for storage.

Action Required:
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:
Additional racking for storage is now available and will be installed by 31/08/15.

Proposed Timescale: 31/08/2015

Theme: Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors noted that there were issues with a number of the pressure relieving mattresses in place for residents including, broken screens, broken alarm buttons, mattresses set at the incorrect setting, and no available maintenance records.

Action Required:
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:
A review of all pressure relieving mattresses is underway. All mattresses will be catalogued and asset numbered for future reference and maintenance records. All repairs required will be carried out and current maintenance/service records of repairs will be updated and maintained for all mattresses. The repairs will include the calibration of all units to ensure they are working effectively and settings are legible. Since the inspection took place five new pressure relieving mattresses are now in place.

Proposed Timescale: 30/09/2015

Outcome 15: Food and Nutrition
Theme: Person-centred care and support
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The menus were not reviewed by a dietician, to ensure that the nutritional needs of residents were being met.

**Action Required:**
Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

**Please state the actions you have taken or are planning to take:**
The services of a suitably qualified health care professional (Dietician) in nutritional needs will be engaged by Talbot Nursing Home. The service will include consultations, diet reviews, and calorie and nutrient analysis of menus. In this regard the service is scheduled to commence on 21st August 2015.

**Proposed Timescale:** 21/08/2015

**Theme:**  
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A number of the mince moist meals were not sufficiently hot at the time of serving on one of the units and had to be sent back to the kitchen on more than one occasion.

**Action Required:**
Under Regulation 18(1)(c)(i) you are required to: Provide each resident with adequate quantities of food and drink which are properly and safely prepared, cooked and served.

**Please state the actions you have taken or are planning to take:**
All food temperatures are checked/probed and recorded prior to leaving the kitchen. Fridge temperatures are recorded twice daily. With effect from Sunday 5th July 2015 the system for serving trays to individual residents in their rooms has been revised so as to ensure that food is served at appropriate temperatures at all times. This is achieved by reducing the number of trays taken from the kitchen at any one time by an individual member of staff from six to two.

**Proposed Timescale:** 18/08/2015

**Theme:**  
Person-centred care and support
The number of staff available to assist residents with meals on unit C was reduced as two healthcare assistants from this unit assisted in the dining room in unit D.

Residents who required full assistance with eating had their meals served early because there were not adequate staff to provide the assistance required to all residents at mealtimes

**Action Required:**
Under Regulation 18(3) you are required to: Ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

**Please state the actions you have taken or are planning to take:**
Talbot Lodge Nursing Home comprises of four areas, totalling 111 beds. There are three separate dining rooms in the nursing home and residents from the four areas share the use of the three dining rooms. A number of residents from Area C use the new dining room in Area D and to ensure continuity of care for those residents, care staff assigned to Area C assists the residents from their area in the dining room in Area D.

The following is the schedule of commencement times for resident's meals.

<table>
<thead>
<tr>
<th>Time</th>
<th>Meal</th>
</tr>
</thead>
<tbody>
<tr>
<td>08.30am</td>
<td>Breakfast</td>
</tr>
<tr>
<td>10.30am</td>
<td>Mid-Morning Tea</td>
</tr>
<tr>
<td>12.15pm</td>
<td>Lunch</td>
</tr>
<tr>
<td>03.00pm</td>
<td>Afternoon Tea</td>
</tr>
<tr>
<td>04.15pm</td>
<td>Tea</td>
</tr>
<tr>
<td>07.00pm</td>
<td>Evening Tea</td>
</tr>
</tbody>
</table>

Supper is also available.

Kitchen staff commence duty at 7.30am and breakfast is served at 8.30am. However a number of residents are awake earlier and request an early breakfast and this is facilitated. A list of residents requesting an early breakfast was shown to the inspection team during the course of the inspection. All staff have been instructed that at no time should any resident be served meals at times to facilitate operational routines.

A comprehensive review of staff allocations based on dependency levels/assessed needs of residents, bed numbers and rosters will be completed by 31/07/15. This review will consider if the impact of the increase in bed numbers and changing needs of residents are adequately provided for in the numbers employed.

A staff allocations index which will contribute to the decision making process on staff allocations based on the dependency level/assessed needs of residents will be finalised by 31/07/15. The index will be used to ensure that the assessed needs of residents are reflected in how staff are allocated.

The issues of staffing levels, work practices and roster scheduling will be externally reviewed and reported on. This will be completed by 21/08/15. Any recommendations arising from the review will be carefully considered and an action plan to give effect to the recommendations will be developed.

The additional allocation of 96 nursing hours per week together with an increase of 84 hours per week in the allocation of HCA hours for day duty will provide additional support for residents at mealtimes.
Proposed Timescale: 01/10/2015

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not seen to offer additional fluids to less able residents when temperatures were high.

Action Required:
Under Regulation 18(2) you are required to: Provide meals, refreshments and snacks at all reasonable times.

Please state the actions you have taken or are planning to take:
All staff have been advised of the importance of fluid intake, details of which must be accurately and contemporaneously recorded in the resident’s records. This will be supervised by the Nursing staff and monitored by the PIC. Where necessary residents will continue to be supported with fluid intake.
The importance of fluid intake and accurate record keeping is included in the induction programme provided to all staff. Refresher training will now be provided.
Food and fluid balance record sheet has been revised to facilitate the recording of additional relevant information.

Proposed Timescale: 31/08/2015

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The number and skill mix of staff was not sufficient to meet the needs of the residents. This resulted in poor outcomes for residents as outlined in the report.

Action Required:
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
1. An additional staff member has been rostered on night duty shift in Area A with effect from 02/07/15 pending a review of staff allocations.
2. A comprehensive review of staff allocations based on dependency levels/assessed needs of residents, bed numbers and rosters will be completed by 31/07/15. This review will consider if the impact of the increase in bed numbers and changing needs of residents are adequately provided for in the numbers employed.
3. A staff allocations index which will contribute to the decision making process on staff
allocations based on the dependency level/assessed needs of residents will be finalised by 31/07/15. The index will be used to ensure that the assessed needs of residents are reflected in how staff are allocated.

4. On completion of the statistical analysis associated with actions (2) and (3) above, the issues of staffing levels, skill mix, supervision, work practices, experience, roster scheduling will be externally reviewed and reported on. This will be completed by 21/08/15. This review will also look at the impact on staffing of factors arising from the design/layout of the centre. Any recommendations arising from the review will be carefully considered and an action plan to give effect to the recommendations will be developed.

As contingency cover for unforeseen absences, with effect from 09/07/15 an additional member of staff is rostered on day duty for up to 12 hours if required pending completion of numbers (2), (3) and (4) above. This arrangement will remain in place until 21/08/15. Presently the extra additional rostered staff member is a Health Care Assistant or a pre-registered Nurse. It can also be a staff nurse pending nursing availability. ‘If required’ relates to the duration of the shift the staff member is required to cover. Not all shifts are 12 hours long and the approval is in place to cover up to 12 hours. The requirement is automatic for the duration of the shift that is vacant.

A computerised Time Management System has been purchased and will be implemented before the 31/08/15. This system will give real time information in relation to staffing levels on duty at any given time. It will also improve management oversight and facilitate early implementation of appropriate measures in response to unforeseen absences. The management information available from the system will be used to keep under constant review the effectiveness of systems in place to have full complements of staff at work at all times. Immediately on coming on duty managers will be able to verify staffing levels and initiate contingency arrangements if necessary to achieve full staffing complement. It will also provide quality management information in relation to absences which will allow management to identify and analyse trends, establish contributing factors that give rise to absences and thereafter put measures in place to reduce the overall level of absence. With the introduction of the new Time Management System the existing roster documentation will be reviewed with a view to making it more user friendly.

To increase our relief cover capacity for unforeseen absences we are currently recruiting additional part time and temporary staff. In this regard we have advertised on 17th July 2015 for nursing staff and in earlier in July for Health Care Assistants. Recruitment of suitably qualified and experienced staff is an on-going process. Currently we have 3 nurses undertaking an adaptation programme, 1 nurse will commence an adaptation programme on 10/08/15, and 5 nurses are scheduled for an adaptation programme later this year.

With effect from 13/07/15, staffing allocations and replacement levels will be a standing item on the Management Team agenda in the future. It will also be on the agenda for Performance Management meetings with the relevant operational managers.

To improve the skill mix and to ensure the effective delivery of care an additional allocation of 96 nursing hours per week has been approved. In addition an increase of 84 hours per week in the allocation of HCA hours for day duty has been sanctioned. Recruitment to fill these hours has commenced. Subject to the current availability of staff and the success of the recruitment processes currently underway these additional
hours are being implemented with immediate effect. Pending the outcome of the recruitment process for nursing staff a contract has been signed with a Nursing Agency to supply staff when available.

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**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff were not appropriately supervised and this led to poor outcomes for residents as detailed in the report.

**Action Required:**
Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

**Please state the actions you have taken or are planning to take:**
The issue of supervision will be considered as part of the review which is scheduled to be completed by 21/08/15.
To ensure consistent and effective levels of clinical supervision are in place, clinical management structures are being enhanced as follows.
Appointment of a Clinical Services Manager. This is a very senior appointment to lead the clinical team. The person appointed will also act as Provider Nominee and Person In-Charge and will be required to address all of the issues highlighted in the report on the most recent inspection.
The Clinical Services Manager will be supported by two senior nurse managers who will be assigned to supervision of staff and service provision to residents. They will also be required to carry out administrative and operational duties that will facilitate the CNM’s and nursing staff to concentrate on direct care to residents and supervision of HCA’s.

| **Proposed Timescale:** 01/10/2015 |