## Health Information and Quality Authority
### Regulation Directorate

### Compliance Monitoring Inspection report
Designated Centres under Health Act 2007, as amended

<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>
</tr>
<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:paulinec@talbotgroup.ie">paulinec@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>
</tr>
<tr>
<td>Registered provider:</td>
<td>Kinsealy Properties Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Pauline Connor</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Nuala Rafferty</td>
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<tr>
<td>Support inspector(s):</td>
<td>Jim Kee</td>
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<tr>
<td>Type of inspection</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>95</td>
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<td>Number of vacancies on the date of inspection:</td>
<td>16</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.
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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 1 day(s).

The inspection took place over the following dates and times
From: 16 February 2016 06:00  To: 16 February 2016 18:00

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

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<td>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 15: Food and Nutrition</td>
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<td>Outcome 16: Residents’ Rights, Dignity and</td>
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<tr>
<td>Consultation</td>
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<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Non Compliant - Moderate</td>
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Summary of findings from this inspection
The purpose of this inspection was to follow up on the action plan and provider’s response to the previous inspection carried out 02 December 2015.

Notification of significant incidents and unsolicited information received by the Authority following the last inspection was also considered and reviewed.

There were 95 residents, one resident was in hospital and there were 16 vacancies. The purpose of the inspection was explained and matters arising from the previous inspection were discussed and clarified. The person in charge and senior management team facilitated the inspection and attended feedback at the end of the inspection.

Overall inspectors found improvements made since the last inspection and actions had progressed. The environment was clean, warm and well maintained, and the atmosphere was calm. Staff were knowledgeable of residents and their abilities and needs and residents spoken too were complimentary of improvements made particularly in relation to the programme of activities now available.
While much improvement was noted, further development was required in relation to the management and evaluation of risks particularly procedures in place to manage risks of elopement. Despite the efforts of the provider to maintain adequate staffing levels, challenges to the recruitment, retention and replacement of staff persist. This required ongoing and sustained improvement.

The findings are outlined within the report and improvements required are outlined in the action plan at the end of this report.

**Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.**

**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):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Governance systems were found to have improved on this inspection. The provider who is also the person in charge (PIC) along with the director of care (DOC) had commenced implementing many of the actions contained in their response to the actions arising from the previous inspection. Monthly management meetings were in place, minutes of the initial meeting reviewed included discussions on staff training, staff retention and recruitment, incident analysis, clinical practice and development of activities.

Actions addressed included:

- Improvements to the system in place to monitor quality and safety of care and the quality of life of residents. A comprehensive review of the standard of care delivered to residents focused on direct care practices. Issues which arose following the last inspection were used as learning to improve care practices. Monitoring of clinical care was also in place with audits and analysis of incidents such as responsive behaviours and falls. Audits were also carried out on nutrition management and medication administration.

Improvements found to the standard of care delivered is reported under Outcomes 7, 11 and 15 of this report.
Communication within and between grades of staff and teams across all units in the centre had improved. Formal handovers still took place at the start and end of shift but an additional handover session had commenced in the early afternoon to update staff on resident's overall condition and health status. Roles and responsibilities of each staff person had been reviewed and although revised job descriptions were not yet rolled out, staff were much clearer on their own role and the role of others within the team. This included a review of the role and responsibilities of the entire senior management team within Talbot lodge, all clinical nurse managers' nurses and healthcare assistants.

Supervision systems were more defined and although not yet embedded were being implemented in practice. These included unannounced late night and early morning visits by the PIC and DOC to ensure appropriate and timely care interventions were being delivered in a person centred manner. A lead healthcare assistant role was also in place to support the nurse in charge on each unit by communicating any issues or concerns relating to residents, ensure staff allocations were implemented, co ordinate care delivery, meal service and assistance and link with activities coordinator to ensure residents were facilitated to participate in activities.

Monitoring and management of incidents such as falls and responsive behaviours had improved. Measures implemented included increased supervision at specific times following trend analysis and moving and handling training.

Contingency staff cover of one extra staff rostered for up to 12 hours daily as cover for unforeseen absences was in place.

The involvement of all nursing staff in the development and review of care assessment and planning had commenced although it was noted that training and a high level of support by the nursing management team was still required. Inspectors found that these governance systems had contributed to an overall improvement in care practices but it was noted that these arrangements were very recent over the previous six week period and needed to be embedded into culture and practice.

Aspects of the actions required from the previous inspection which were not addressed included;

- Inspectors found that the role and responsibilities of the nurse in charge on night shift was not clear and the nurse not formally identified. All staff said that the most senior nurse on duty was in charge. The most senior nurse (being the nurse working in the centre for the longest time) was not clear on the responsibilities of this role. For example, staff were not clear whether it was the nurse on the particular unit or the senior nurse who would be responsible for coordinating or making arrangements in the event of a resident being unwell and requiring medical attention or in the event of an emergency.

- On call arrangements of the senior management team for support or advice at night were not documented.

- Adequate staffing resources and appropriate skill mix to ensure the delivery of safe, suitable and sufficient care to residents' was not in place at all times. Despite the efforts of the provider to maintain adequate staffing levels, challenges to the recruitment, retention and replacement of staff remained and gaps persisted. The total staffing numbers on night shift was 10. This represented an increase from previous levels of nine. This increased staffing was put in place as a result of an increase in the numbers of residents and physical extension of unit A and findings of previous inspections.
clinical nurse manager was due to be rostered on night shift in addition to the current staffing to provide governance support to staff and supervise and maintain safe delivery of care. But this was not in place on this inspection.

- Turnover and replacement of staff remained a challenge. Inspectors learned that one of the recently appointed DOC had transferred to another centre within the group managed by company and more healthcare assistant and nursing staff had also left. Evidence of ongoing recruitment, engagement of additional nursing agencies to provide relief cover and expected dates of return of staff on various forms of leave was available and noted by the inspection team. However, it was also noted that on the days immediately preceding and following inspection, nursing staff levels were depleted by one on each day and could not be replaced. On the day of inspection a pre registered nurse was unexpectedly absent and was also not replaced.

This poses a potential risk to care delivery and governance given that staffing skill mix is at a minimum, baseline for professional nursing care. An action in relation to staffing resources, referenced in detail under Outcome 18 of this report, is included in this outcome.

**Judgment:**
Non Compliant - Moderate

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**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.

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**Theme:**
Safe care and support

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

**Findings:**
Issues arising from the last inspection were found to be addressed including;
A review of the use of restraint found that there was a further reduction in the use of bed rails throughout the centre although bed rails were still in place for some residents. It was found that revised assessments were now in place for this type of restraint and were in the process of being completed. These assessments gave a clear rationale for their use with evidence of alternatives considered or trialled and future measures to be trialled identified. A culture of promoting a restraint free environment with an increase in the use of alternative safety measures such as bed alarms, roll out mats and low low beds continued to be a priority for the management team.

Evidence that positive behaviour support plans to appropriately and consistently manage behaviours that challenge, were being developed was found. Although those in place required to be improved and these plans were not in place for all residents, it was noted
that plans were prioritised for those residents identified as having responsive behaviours that negatively impacted on others.

The management of negative interactions between residents was improved. There were effective and appropriate measures in place. Improvements in the appropriateness and safety of care practices and the protection of residents’ rights during care delivery were also found. Staff had received training on the prevention of elder abuse and on providing person centred care to the person with dementia. The policy was updated to reflect the most recent HSE guidance on safeguarding vulnerable adults and all staff spoken to were clear on their role and responsibilities in relation to reporting abuse. Staff were knowledgeable in recognising the possible signs and symptoms, responding to and managing abuse. This was evident in the appropriate notification to the authority of incidents of negative peer to peer interactions and on review of the incident log within the centre.

**Judgment:**
Compliant

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

**Findings:**
Actions were found to be partially addressed under this outcome. Inspectors found that ongoing training on fire safety and evacuation processes was being delivered. There was a schedule of planned fire drills in place for the year that included one fire drill per calendar month. The fire drill that had taken place in January had been conducted in Area A, based on a scenario of a fire in one room. Records of this drill indicated that a staged evacuation had not taken place as part of this drill. Issues arising during the drill were documented as having been addressed. However, fire drills which simulated night time staffing levels and conditions had not yet taken place. Inspectors also found that personal evacuation plans were in place to guide staff on the safe evacuation of each individual resident. These plans included the level of assistance and guidance the individual required to safely exit the building in an emergency. But some improvements were required to the plans. For example all plans did not identify whether the resident was at risk of absconion and required supervision or to what extent staff could expect the resident to comply with the evacuation process. The risk management policy which covered the identification, assessment and management of risks and a risk register was under review at the time of inspection. Processes in place for investigating and learning from serious incidents/adverse events involving residents had improved as outlined under Outcome 2. A new incident report
A form was being used to record all incidents. Incident analysis was being conducted in each area by type and time of incident to ensure trends could be identified. A new procedure for reporting, monitoring and management of adverse incidents had been implemented to ensure a consistent approach throughout the centre. Measures to minimise and manage risks associated with falls and responsive behaviours were being implemented.

However further improvements were found to be required. The Authority had been notified as required in relation to an unexplained absence of a resident. Inspectors also learned that another resident had also recently been able to exit the building but had only just reached the far side of the door before being seen and brought back inside by a member of staff. Although the resident who left the centre had reached the driveway and subsequently left the grounds, this resident was accompanied by staff for the duration of time they were out of the centre. Although a policy was in place on the management of a Missing Person's incident, it was found that a specific procedure was not in place to guide staff on how to manage such an incident.

Although staff demonstrated a common sense approach it was noted that a documented formal plan was not in place which identified for example, who would take charge of the incident, the initial search areas, extending search areas, formation of search parties and the resources available to support a search such as, hi visibility jackets, foil blankets, torch, mobile phones or two way radio handsets.

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
The actions arising from the last inspection were fully addressed in that the duration of the administration of medication was found to be within the timeframes recommended for administration for medications prescribed to residents at specific times.

**Judgment:**
Compliant
**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:**
Access to medical and allied health professionals was available. Residents had access to a general practitioner (GP)
Evidence of access to allied health professionals was also found with documented visits, assessments and recommendations by occupational therapy, physiotherapy and psychology dental, optical and podiatry services. Access to palliative care specialists was available through the primary care and acute hospital services. Increased access to a dietician consultancy service was provided.
Improvements to the standard of care provided was found on this inspection with more timely responsiveness and referral to allied health professionals to manage risks associated with deteriorating clinical needs. These included improvements to the management of risks associated with; nutrition, pressure ulcers, falls and responsive behaviours.

A new system was being implemented to improve processes in place for the assessment planning implementation and review of healthcare needs. This involved a move from paper based systems to a computerised system. Although it is acknowledged that the new system was not yet fully operational and staff were in the process of transferring all information on to the computer data base it was noted that some further improvements were required.
These included;
- Risk assessment tools to evaluate levels of risk for deterioration were not fully completed for every identified need. Examples include; mini nutritional assessments; risks of abscondion and personal evacuation assessment. It was also noted that where residents had several risk assessments in place for a variety of needs the information contained on the most recent assessments was conflicting. Examples included; activities of daily living assessment identified one resident’s vision as normal and the mini mental assessment identified cognition as severely impaired but the personal evacuation assessment identified vision as impaired and cognition as normal.
A healthcare plan for every identified health or social care problem was in place to maintain residents' health and well being and monitor improvements or deterioration.
However, where care plans were in place they did not contain enough detail to ensure they were effectively managing the health problem such as positive behaviour support plans did not include the form the behaviours might take, triggers associated with the behaviour, distraction or de escalation techniques to manage the behaviours. Although the management of nutrition had improved it was noted that all care plans did not include the recommendations of allied health professionals, frequency of weight monitoring or techniques to manage refusal of intake. Quarterly reviews did not include a determination of effectiveness to ensure improvement in the standard of care being delivered.

It was found that the quality of clinical documentation, together with practices observed, had improved and that a better standard of care was now being provided to residents’. However, ongoing support and training was still required to embed improvements to practices and further improve the standard of care delivery. Some aspects of documentation and recording were not improved including, the daily nursing progress notes which were primarily summation and did not always refer to changes in health care plans or changes to treatments or recommendations made by clinicians. Care plans, nursing progress notes and other supporting documentation were not appropriately linked to ensure that a high standard of evidence based nursing care was being provided or give a clear and accurate picture of residents’ overall health management. Although it was noted that staff were being provided with better support and supervision by the senior management team, specifically the person in charge and the director of care. This is also referenced under Outcome 18

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
The actions arising from the last inspection were fully addressed in that a new designated smoking area was identified and in use. This area was heated with safe flooring and safe access. This is now a combined area for both staff and residents which provides a further element of safety when residents are using it.
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:
As referenced under outcome 11 improvements to the assessment and monitoring of residents with nutritional needs were found. Evidence of referral to relevant allied health professional including dietician or speech and language therapists was found and a system was established to monitor the intake of residents identified as at risk of malnutrition.

The system of recording intake was detailed enough to ensure meaningful analysis of the information to improve health outcomes. A form which enabled staff to record the amount taken in terms of percentage had been devised and was implemented. Other improvements included recommendations of the dietician to improve the menu by offering alternatives for mid morning snacks such as soup fruit or yoghurt or offering high calorie desserts to residents who had poor intake were observed. Changes to the meal service were found to have improved the ability of staff to maintain the temperature of food so that it didn't go cold before residents were assisted with their meal. Meal service was now staggered to give residents a chance to have their meal at their own pace again without other aspects of the meal going cold in the meantime.

Judgment:
Compliant
Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident’s privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

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:
On the day of inspection, a varied programme of activities was observed to be delivered and included; Group therapies such as reminiscence and sonas, arts and crafts, bingo, quiz, Rosary prayers and computer sessions. Individual activities such as hand massage and news reading took place for residents unable or who preferred not to participate in the group sessions. Residents' life stories were in the process of being collated by staff to inform the activity programme and make it more relevant to residents past lives and interests.

The inspectors noted the substantial increase in the amount of resources now allocated to the social care needs of residents since the previous inspection. Other activities in the programme included; gardening, flower arranging and pottery. A minibus to facilitate residents individual and group outings had been sourced.

In conversation with several residents all were very happy with the increased level of activity and both residents and staff talked about the enjoyment it created. Some residents’ talent for piano playing and singing had been discovered and impromptu sing a long sessions were becoming regular.

Details of the next residents’ meeting were on display on the notice board in each unit. This notice board also displayed contact details for an independent advocacy service, information on the complaints process and information on the activities programme. Residents’ participation in various activities were being recorded. Inspectors reviewed details of the recently held residents’ meetings, which had included discussion on a variety of topics including staffing, food, activities and outings.

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

**Findings:**
Improvements were found to the level of care delivered to residents on this inspection as previously referenced under Outcomes 2 and 11 of this report. Although on this inspection the levels and skill mix of staff were sufficient to meet the needs of residents, this was because the provider had ceased admissions and the number of residents in the centre had fallen to 95 with 16 vacancies. As a direct result of this the ratio of staff to residents had improved. The cessation of admissions had also provided staff with opportunities to become more familiar with their residents needs and implement strategies to improve healthcare.

Overall, the direct care staffing levels and skill mix of staff had not changed significantly since the previous inspection. An additional member of staff was rostered on night duty bringing the overall number up from nine to ten. Inspectors found that the grade of this staff person was dependent on the availability of relief and could be either a nurse or healthcare assistant.

It was further noted that the skill mix of staff on night duty had depleted in that a clinical nurse manager was no longer available to be rostered on night shifts. As was the case on the last inspection, action plan responses to actions arising under this outcome from the last inspection were not fully implemented or sustained by the provider. As previously referenced under Outcome 2 despite the efforts of the provider to maintain adequate staffing levels, challenges to the recruitment, retention and replacement of staff remained and gaps persisted.

Actions which were addressed included;
- activity staffing levels increased to three with one being a full time activities coordinator.
- The additional healthcare assistant to respond to unforeseen absences on planned rosters maintained.
- Review of the role and responsibilities of all staff grades included the development of a team leader role for healthcare assistants to enable clarity on supervision of practice and
improved implementation of care regimes.
- Improved staff training and development systems were put in place. All staff spoken to confirmed they had received updated training on moving and handling principles; prevention of elder abuse and safeguarding vulnerable persons; dementia care; fire safety and evacuation. In house mentoring was also being provided by the nurse management team on care planning and assessment and recording and documentation of care.

Other improvements noted included an increase in the level of operational supervision and support provided by the person in charge and director of care services. However, other aspects of the action plan responses had not been implemented or could not be sustained by the provider. These included;
- Six nursing vacancies were not yet filled.
- Additional nurse rostered on area A on night shift although four staff were rostered the additional person was not always a qualified nurse.
- Provision of supernumerary clinical nurse manager to provide managerial and clinical support and advice to night staff not in place.
- The recommendations of the external staffing review were still not fully implemented in relation to the additional 96 hours of nursing. On comparison of an analysis of a sample of rosters over a three month period and the recommendations from the external staffing review significant gaps in the provision of these recommended nursing hours persist.

Further depletion of nursing staff due to the transfer of one director of care services to another centre in the group and two more nurse resignations was found. A high turnover rate persists with inspectors told more healthcare staff were also leaving in the immediate future. The general manager told inspectors that there were a number of nursing staff due to return from a variety of leave absences in the coming weeks and recruitment was ongoing. Evidence of this was viewed.

Inspectors noted that there remained a heavy reliance on agency staff and although the ability to fill these vacancies had improved with two regular agencies being used not all absences were filled. On the week of the inspection a total of ten planned nursing shifts(six at night) and six healthcare assistant shifts required to be filled. On the days immediately preceding and following this inspection due to unforeseen absences a nursing shift was not filled on either day.

The resident profile had not changed significantly since the last inspection with a similar age profile of approximately 50% between 85 and 95 years old and 75% assessed as being at high/maximum dependency, meaning that they required the assistance of two staff with most or all of the activities of daily living. Almost 60% of the resident population also had a formal diagnosis of dementia, cognitive impairment or intellectual disabilities. It had been previously found that one third of these exhibited responsive behaviours that could be challenging.

Inspectors found that the improvements to residents’ standard of care and staffing ratios was due to;
- Improved work systems which need to be embedded in a culture of staff development and person centred care delivery.
- Reduction in resident numbers due to the cessation of admissions.

The senior management team provided the inspectors with proposed staffing levels and
skill mix for maximum numbers of residents at full capacity of 111 residents. On review of the proposed staffing, inspectors found that the baseline ratio of overall staffing numbers would be approximately 1:5 for day shift and 1:12 for nights. However, it was noted that the ratio of nurse to resident remained unchanged at 1:16 on day shift and night duty at 1:28. Both of which remain outside safe staffing levels recommended by nursing bodies in Ireland and the U.K. It was also noted that the proposed levels did not take account of the design and layout of the centre or the dependency levels of the resident population going forward or of the recommended 20% additional staff required to cover replacement for all leave types.

An action in relation to staffing resources is included under Outcome 2.

**Judgment:**
Non Compliant - Moderate

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**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:*

Nuala Rafferty  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Talbot Lodge Nursing Home</th>
</tr>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000182</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>16/02/2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>15/03/2016</td>
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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 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence that there were sufficient resources in terms of staffing levels and skill mix to provide safe sufficient and appropriate care to residents at all times was not available. Proposed staffing resources to manage the needs of maximum numbers of residents when the centre reopens to admission do not represent an increase in skill mix and the levels proposed do not take account of the design and layout of the centre, the dependency levels of the resident population going forward or of the recommended

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
20% additional staff required to cover replacement for all leave types

1. **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:**
Based on full occupancy the following staff complements apply.

- The nursing complement has been revised as follows.

The day duty complement of nursing staff is 7. In addition the following are also in place on day duty –

Clinical Services Manager (Monday – Friday)  
Director of Care (Monday - Friday)  
Clinical Nurse Manager (Monday – Sunday)

The night duty complement of Nursing Staff is 5 (1X CNM and 4 X Staff Nurses)

- HCA complement on day duty has been revised to 20.

- HCA complement on night duty is 5.

- The complement of Social Care/Activity Staff has been increased from 1 to 3.

- The above complements give a combined Nurse/HCA to resident ratio of 1:4 on day duty and 1:11 on night duty. The Social Care/Activity staff of 3 are in addition to the day duty ratio.

Currently we are actively recruiting additional Nursing and HCA Staff to ensure full complements on each roster and adequate cover for all planned and unplanned absences including all leave types.

The filling of nursing positions is dependent on successful completion of Adaptation Programme and/or registration with NMBI. Every effort is being made to expedite these appointments. In the interim, when available agency nursing will be used to maintain staffing levels.

**Proposed Timescale:** 31/05/2016

**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:
A specific procedure with a documented formal plan was not in place to guide staff on the appropriate management of a Missing Person’s incident.

2. Action Required:
Under Regulation 26(1)(c)(ii) 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 unexplained absence of any resident.

Please state the actions you have taken or are planning to take:
The Missing Person’s policy has been reviewed and now includes procedures on how to guide staff on the management of a Missing Person incident. The policy has been circulated and all staff have been made aware of the procedures to be followed in the event of a Missing Person incident.

**Proposed Timescale:** 15/03/2016

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire drills which simulate night conditions and staffing were not held.

3. Action Required:
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
The Fire Policy has been reviewed to ensure all staff and as appropriate residents are aware of the procedures to be followed in the event of a fire.

A simulated night time Fire Drill was held in the centre on the 10th March 2016.

The Fire Drills schedule has been updated to clearly identify dates for simulated night time and daytime conditions to be conducted throughout the year to ensure staff awareness and embed practice in accordance with Fire Policy.

Fire Warden training is scheduled to take place on 22/03/16

**Proposed Timescale:** 30/03/2016

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvements to the personal evacuation plans in place to ensure the safe evacuation
and placement of residents in the event of an emergency were found to be required such as; inclusion of the potential risk of absconsion, requirement for supervision and extent or level of compliance staff could expect from each resident.

4. **Action Required:**
Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

**Please state the actions you have taken or are planning to take:**
A process of review of all personal evacuation plans is underway to ensure that they are resident specific to individual resident’s assessed needs. The personal evacuation plans now identify the mode of evacuation and level of support required.

**Proposed Timescale:** 30/04/2016

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**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:**
Assessment and care planning were not specific enough to direct the care to be delivered or guide staff on the appropriate use of interventions to consistently manage the identified need.
Complete comprehensive nursing assessments were not carried out for each resident.

5. **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:**
There is a process of continuous review of resident comprehensive nursing assessments and care plans in place to ensure care plans reflect a person centred approach to individual resident identified needs. For new admissions a comprehensive nursing assessment will be carried out immediately before or on admission.

The review process in place involves formally reviewing and evaluating care plans in consultation with the resident and where appropriate the residents family, as indicated by the residents changing needs and no less frequently than four monthly intervals.

Guidance and support will continue to be given to staff nurses on person centred care planning.

A care plan audit tool has been implemented. Results from care plan audits will be communicated directly to the key worker nurse who will ensure that the resident care
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Reviews of care plans did not include a determination of the effectiveness of the plans to manage the needs identified.

6. 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:
All residents’ care plans are being reviewed to ensure care plans reflect a person centred approach to individual resident identified needs.

The review process in place involves formally reviewing and evaluating care plans in consultation with the resident and where appropriate the residents family, as indicated by the residents changing needs and no less frequently than four monthly intervals.

Guidance and support is being provided to staff nurses on person centred care planning.

A care plan audit tool has been implemented. Results from care plan audits will be communicated directly to the key worker nurse who will ensure that the resident care plan reflects identified needs.

Results from care plan audits will also be communicated to staff during the Unit Managers meetings and Unit Staff meetings on a monthly basis or more regularly if required. The audit results will be used to improve learning, practice and quality of care delivered.

Proposed Timescale: 30/04/2016
Theme: Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in
the following respect:
The documentation of care was not sufficiently accurate or appropriately linked to ensure that a high standard of evidence based nursing care was being provided or give a clear and accurate picture of residents’ overall health management.

7. Action Required:
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:
All residents’ care plans are being reviewed to ensure care plans reflect a person centred approach to individual resident identified needs.

The review process in place involves formally reviewing and evaluating care plans in consultation with the resident and where appropriate the residents family, as indicated by the residents changing needs and no less frequently than four monthly intervals.

Guidance and support is being provided to staff nurses on person centred care planning.

A care plan audit tool has been implemented. Results from care plan audits will be communicated directly to the key worker nurse who will ensure that the resident care plan reflects identified needs.

Results from care plan audits will also be communicated to staff during the Unit Mangers meetings and Unit Staff meetings on a monthly basis or more regularly if required. The audit results will be used to improve learning, practice and quality of care delivered.

Proposed Timescale: 30/04/2016

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence that the actual number of nursing staff on duty providing direct care to residents, on a daily basis, was sufficient to ensure a safe standard of suitable care was delivered was not found .

8. 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:
Based on full occupancy the following staff complements apply.

• The nursing complement has been revised as follows.

The day duty complement of nursing staff is 7. In addition the following are also in place on day duty –

The night duty complement of Nursing Staff is 5 (1X CNM and 4 X Staff Nurses)

• HCA complement on day duty has been revised to 20.

• HCA complement on night duty is 5.

• The complement of Social Care/Activity Staff has been increased from 1 to 3.

• The above complements give a combined Nurse/HCA to resident ratio of 1:4 on day duty and 1:11 on night duty. The Social Care/Activity staff of 3 are in addition to the day duty ratio.

Currently we are actively recruiting additional Nursing and HCA Staff to ensure full complements on each roster and adequate cover for all planned and unplanned absences including all leave types.

The filling of nursing positions is dependent on successful completion of Adaptation Programme and/or registration with NMBI. Every effort is being made to expedite these appointments. In the interim, when available agency nursing will be used to maintain staffing levels.

**Proposed Timescale:** 31/05/2016