Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Our Lady's Manor Nursing Home
Name of provider:	Newbrook Nursing Home Unlimited Company
Address of centre:	Edgeworthstown, Longford
Type of inspection:	Unannounced
Date of inspection:	16 May 2024
Centre ID:	OSV-0004632
Fieldwork ID:	MON-0042682

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Our Lady's Manor Nursing Home can accommodate up to 61 residents of all dependency levels. It provides 24 hour nursing care for older persons with physical or intellectual disabilities, dementia, acquired brain injury and palliative care on long-term, short-term, convalescence and respite basis. Residents are accommodated over three floor levels in 34 single bedrooms, 12 double room and one triple room, some of which have en suite facilities. The main reception, a variety of communal areas and a large oratory are located on the ground floor. The grounds are landscaped and include a garden for residents and a large private vegetable garden. The building, which was originally a convent, had been converted and undergone extension and modification over the years to improve facilities for residents. The designated centre is situated in Edgeworthstown, 12 km away from Longford, and is conveniently serviced by nearby restaurants, public houses, libraries and community halls. Free parking facilities are available on site.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	51

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 16 May 2024	09:30hrs to 18:30hrs	Gordon Ellis	Lead
Thursday 30 May 2024	09:30hrs to 16:20hrs	Gordon Ellis	Lead
Thursday 16 May 2024	09:30hrs to 18:30hrs	Brid McGoldrick	Support
Thursday 30 May 2024	09:30hrs to 16:20hrs	Brid McGoldrick	Support

What residents told us and what inspectors observed

This unannounced inspection was carried out over two days. There were 51 residents accommodated in the centre on both days of the inspection.

The inspectors were met by the person in charge who facilitated the inspection. Following an introductory meeting, the inspectors completed a walk around of the centre. This gave the inspectors an opportunity to meet with staff and residents and observe life in the centre.

Staff were observed to be very kind and respectful to residents who were mobilising around the centre. From speaking with residents and observations, inspectors found that residents were satisfied with the service provided, staff were respectful towards residents and responsive to their needs. Inspectors were told that the menu options for breakfast had improved.

Residents' bedrooms were generally personalised with items such as family photographs, colour coordinated soft furnishings, and ornaments. In general, residents were satisfied with their bedrooms and had comfortable furnishings in them. Inspectors observed that for the most part, residents were socially engaged during the inspection. This is detailed under regulation 5 : Individual assessment and care plan.

There was a small sitting area for residents, however it was along an emergency escape route, there was no safe and secure outdoor area available for residents to sit and relax if they wished.

Residents' wishes were respected, for example, to attend a sitting room or to stay in their own rooms. On the first day of the inspection, inspectors found that staff were not present with residents on the lower floor who remained in their rooms to respond to their needs for assistance and support. Some of these residents were at assessed risk of falling.

The inspectors spoke with visitors who expressed satisfaction with the service provided. There was a monthly newsletter for residents and families with pictures of activities with residents who attended during the previous month. Inspectors saw that there were artwork classes. Birthday cards were made at these classes and residents were observed to be enjoying these activities.

One resident told inspectors that the designated centre was a 'good place to live' and there were more options on the menu for breakfast to cater for each residents choices.

While the centre was comfortable and nicely decorated, the inspectors observed that some aspects of the environment were not in a good state of repair. Some doors and door frames had signs of damage and holes were found in ceiling and wall

areas around service penetrations. There was a lack of hot water at a cleaners sink and a sink located along a corridor when tested by the inspectors. There were inappropriate storage practices in regards to; residents belongings, hoist slings, flammable and combustible items that required immediate action by the provider to mitigate risk of fire.

From a selection of fire doors sampled in the centre, a number of doors had gaps, did not close fully when tested by the inspector and smoke seals were painted over and therefore ineffective with containing the spread of smoke and fire. Main corridors were spacious and the centre was provided with a number of fire exits. However, some corridors were observed to be cluttered with trolleys which obstructed the means of escape.

The inspectors observed that the main fire panel although not located at the front entrance, indicated the system was healthy with no faults registering. Fire action notices for staff and visitors to follow in the event of a fire were lacking in areas of the centre and were not displayed beside the fire panel. Action notices that were displayed were too detailed,the text size was too small to read and these notices were displayed in an area with other displayed notices that would cause confusion and delay for staff to refer to in the event of a fire.

The next two sections of this report presents the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

The findings of this inspection were that the registered provider had failed to put effective oversight and management systems in place to ensure that the service provided was safe in respect of fire safety. A number of immediate actions were issued on the day to the provider in regards to the following:

1. Decluttering and removal of flammable and combustible items from a store room that contained cardboard boxes, paint buckets and a boiler room that contained large quantities of timber on the lower ground floor.
2. The removal of cardboard boxes in a lift machine room on the second floor.
3. The removal of a bag of rubbish from a staff smoking room.

The oversight of fire safety management systems and the processes to identify, and manage fire safety risks were not robust to ensure the safety of residents living in the centre. This was evidenced by the significant fire risk identified by the inspectors that resulted in a number of urgent actions being issued to the provider. The provider's urgent action was required to ensure residents' safe evacuation needs were met, staff fire training, containment and compartmentation measures. These

risks along with additional fire safety risks are outlined under the quality and safety section of this report and under Regulation 28.

This unannounced risk inspection was to monitor the designated centre's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and to follow up on the provider's progress with addressing actions from a previous inspection in May 2023.

The commitments made by the provider from the previous inspection with regards to Regulation 28: fire precautions had been actioned. The provider had a fire safety risk assessment carried out by a competent person in fire safety. The assessment was dated December 2021 and the provider had carried out a significant amount of fire safety works as needing actions that had been identified in the assessment.

However, the fire safety risk assessment was not a fulsome or comprehensive assessment of fire safety as it focused on passive fire resistance and did not assess all aspects of fire safety. For example, compartmentation, fire safety management, evacuation procedures and fire fighting equipment did not form part of the assessment. As a result, significant fire safety risks were identified on this inspection that had not been identified by the provider. Therefore, further action was required from the provider to ensure residents' safety and in order to achieve regulatory compliance on fire precautions. These risks are outlined under the quality and safety section of this report and under Regulation 28:Fire Precautions.

The designated centre is operated by Newbrook Nursing Home Unlimited Company, the director of nursing is supported by a management team that consisted of a person in charge who was supported in their day-to-day role by a regional quality manager. A team of nursing staff provided clinical support along with health care assistants, household, catering and maintenance staff making up the full complement of the staff team. The provider has a number of designated centres and the person in charge benefited from group resources in relation to recruitment and human resource advice, access to training and finances. The operational director for the group was in regular contact with the management team in the centre and provided oversight and support to the person in charge.

There were insufficient resources to meet the assessed needs of residents. Fifty four per cent of residents were assessed as maximum dependency which meant that they required help from one to two staff to assist them with personal hygiene and mobility. There were five staff rostered on night duty to cover three floors. From discussion with staff and reviewing documentation, inspectors observed that there were not enough staff during night time hours to safely evacuate residents. Four residents required two-to-three persons to assist them with evacuation and together with the structural issues found regards ineffective compartmentation and deficiencies to a number of fire doors, assurances were not available that this would be managed safely in the event of an emergency or fire situation with the current night time staffing levels.

Inspectors observed two residents who were complaining of pain and had to wait for staff assistance as staff were busy attending to other residents' needs. The findings

of this inspection confirmed that a full review of staff provision is required to ensure that residents assessed needs are met. Inspectors acknowledge that the provider put an additional person on night duty to facilitate the assessment and completion of fire works.

Monthly governance meetings convened by the provider showed there were systems in place to monitor the quality and safety of the service provided for residents. However this inspection found that the oversight of cleaning practices, staffing and fire safety required strengthening. The provider had failed to achieve compliance with Regulation 28: Fire Precautions on previous inspections in 2021,2022 and 2023.

This inspection found that fire safety management systems in place were not robust. The provider had not taken all necessary steps to ensure compliance with Regulation 28 as evidenced by the number of immediate and urgent actions the provider was required to address. This was further compounded by significant fire safety risks identified on the day of the inspection.Therefore adequate resources and effort from the provider was now required in order to bring the centre into full compliance with regulation 28: Fire Precautions.

The findings relating to fire safety are set out in greater detail in the quality and safety section of the report.

The provider had addressed a number of the actions from the 2023 inspection findings and this included ensuring that menus for each meal were displayed on the notice board and on the dining room table.

Regulation 23: Governance and management

The provider had failed to ensure sufficient staffing resources were in place to meet the assessed needs of the residents on the days of inspection.

- Assurances were not available that there were sufficient staff resources to safely evacuate residents, as this had not been adequately assessed by the provider. There were five staff on duty at night time to cover three floors. There were four residents who required additional resources to safely evacuate, one of these residents resided on the third floor. Furthermore, inspectors identified compartment sizes that were larger than known to staff on the ground, this is discussed under regulation 28:Fire precautions.
- Household staffing was not consistent and did not ensure that residents' were protected from risk of infection. For example, household staffing was reduced to one staff during the weekends to clean the large footprint over three floors. The provider committed to increasing hours on day one of the inspection.
- There was insufficient numbers of nursing staff available during the morning on both days of the inspection to meet the assessed needs, and

dependencies of residents living in the centre. The inspectors found that on two separate occasions staff were not available to respond to residents experiencing pain. Available nursing staff were observed by the inspectors to be attending to other residents needs and their response to residents in pain was delayed. Furthermore from review of residents' care records, inspectors found that while pressure wound management was managed satisfactorily, the pressure wounds occurred in the centre.

The management systems that were in place to monitor key areas such as infection prevention and control and fire safety were not effective and did not ensure that the service provided was safe, appropriate, consistent and effectively monitored. Furthermore, there was insufficient oversight and supervision of staff to ensure that infection prevention and control practices and procedures protected residents from risk of infection. This was evidenced by the following findings;

- The provider had not recognised fire risks found on the inspection. The-day to-day management of fire risk in the centre did not ensure that risks were identified and effectively managed. The inspectors found significant faults with fire doors, containment deficiencies, inadequate assurrances regarding residents' safe evacuation and staff training.
- The provider's in-house fire safety checks had not identified fire risks found by the inspectors that required immediate and urgent actions by the provider to mitigate the risks found. These are outlined in detail under regulation 28.
- Infection prevention and control practices and procedures did not ensure that residents were adequately protected from risk of infection. The inspectors' findings are discussed under Regulation 27: Infection control.

Judgment: Not compliant

Regulation 15: Staffing

On the days of the inspection, the staffing levels and skill-mix were not appropriate to meet the assessed needs of the residents.There was insufficient nursing staff, rostered. Findings in respect of staffing included: For example,

- One household staff was rostered 08:00-16:00 on Saturdays and Sundays, this was not sufficient to cover the extensive footprint of which covered three floors.
- On the days of the inspection the Clinical Nurse Manager was rostered 08:00-16:30 and a nurse 08:00- 20:00. Inspectors observed that the medication administration round took from 08:30 to 11:00 to complete.Two residents were observed to wait for pain medication as staff were busy attending to other residents' needs. Furthermore a review of residents' care records identified that while wound management was well managed, that these

pressure wounds were acquired in the centre. This did not provide assurance that residents skin integrity was being consistently monitored. Inspectors concluded that additional staff are required on the morning shift to meet residents assessed needs.

- A review of the schedule of activities and discussion with staff identified that no dedicated activity were on duty on weekends, the care staff provided activities on weekend in addition to their other duties.

Judgment: Not compliant

Quality and safety

This inspection found that the provider's fire safety arrangements did not adequately protect residents from the risk of fire in the centre and did not ensure the safe and effective evacuation of residents in the event of a fire.

While the Provider had a fire safety risk assessment carried out in December 2021 and actions to address the findings of the assessment had been carried out. However, the fire safety risk assessment was not a fulsome or comprehensive assessment of fire safety.

As a result, the registered provider had continued in failing to meet the regulatory requirements on fire precautions in the centre and had not ensured that residents were protected from the risk of fire. The Provider had continued to be non-compliant with Regulation 28: Fire Precautions over consecutive years from 2019 and up to this current inspection.

The inspectors found uncertainty over means of escape, fire-containment, visual deficiencies in the building fabric, fire doors, inappropriate storage of flammable and combustible material, staff training, evacuation and the provision of emergency lighting to external routes which could lead to serious consequences for residents in an emergency. These are outlined in greater detail under regulation 28 of this report.

Significant effort and resources were now required to ensure that fire risks were addressed in a timely manner.

While there were a number of fire exits and escape routes provided, the means of escape and emergency lighting provided to escape routes required a review by the provider.

A final fire exit from a protected staircase lead to external steps. From here staff and residents would have to be evacuated up the external steps in order to reach a fire assembly point. The inspectors were informed that Staff did not use this fire exit. However, signage was on display that indicated this was a fire exit. Instead staff would by-pass this external fire exit and would re-enter a corridor that led to an

alternative final fire exit. This created a risk to residents who may be evacuated through an area that may be unsafe. Furthermore, in a separate protected staircase it was noted the width of the staircase narrowed below the minimum width required and may be difficult to evacuate residents in the event of a fire to the final fire exit within the protected staircase to the outside.

In addition to this, there was a lack of emergency lighting to some external evacuation routes that lead to the fire assembly points. This required a review in order to ensure adequate illumination would be provided in the event of a night time evacuation.

The inspectors were not assured by the containment measures in some areas of the centre. From a visual inspection of the attic space, the inspectors observed a compartment wall did not appear to be present in the attic space in line with the location of the compartment boundaries as understood by staff and indicated on fire evacuation floor plans. This meant that a larger compartment of 10 residents existed in the centre. This was unknown to the provider or the staff. This had significant consequences for the containment of fire and the evacuation design strategy of the centre which, is based on progressive horizontal evacuation and ultimately for the care and welfare of residents living in the centre.

As the compartmentation boundaries were compromised, the inspectors were not assured there were adequate compartmentation arrangements in place to; facilitate progressive horizontal evacuation, to ensure the safety of residents and staff in the event of a fire and to provide adequate containment from the spread of fire and smoke from one compartment into the adjoining compartments. Furthermore, some compartment boundaries appeared to have 30 minute fire resistant fire door fitted instead of the required 60 minute fire door. The provider was required to urgently address this risk as identified by the inspectors.

The inspectors reviewed the evacuation procedures and staff training records in regards to fire safety. The inspectors were not assured that these were centre specific to the centre. This was further compounded from speaking with staff on duty, some of whom were unsure of the evacuation procedures from certain areas of the centre and the use of fire exits from protected staircases. Action was required by the provider to ensure evacuation routes had been tested and staff were certain on the escape routes to be used in the event of a fire.

In addition to this, there were insufficient resources to meet the assessed needs of residents in the event of an evacuation. The inspectors were informed that the maximum number of staff required to aid in the evacuation of all residents were two staff members. However, it was evident from speaking with staff and reviewing residents' evacuation requirements that a number of residents, one in particular located on the first floor required additional staff to aid in their evacuation. This was not accurately reflected in this resident's evacuation assessment requirements.

Taking into account; the layout of the centre over two floors, the location of residents who required additional staff in an evacuation, the inaccurate evacuation requirements and the current staffing resources on duty at night time created a

significant risk to the residents' safety and current measures in place to safety evacuate them in the event of a fire. An urgent action was issued to the provider in regards to this risk. Inspectors acknowledge that the provider did relocate residents to more suitable areas to facilitate progressive horizontal evacuation and rostered an additional person on night duty to support staff and residents in the event of an evacuation.

The inspector reviewed the fire safety register and noted that parts of it were well organised, in-house periodic fire safety checks were being completed and logged in the register as required. However, deficiencies identified in regard to appropriate storage and wedging of fire doors had not been identified in the in-house routine checks.

Service records were available for the various fire safety and building services, and these were all up to date. There was a fire safety management plan and emergency fire action plan in place. These were found to be comprehensive and informed the fire safety management of the centre

Other concerns were identified in regards to the access fire exits, evacuation floor plans, deficient fire doors, penetrations that required sealing up and evacuation drills. These and other fire safety concerns are detailed further under Regulation 28: Fire Precautions.

The centre had a COVID-19 infection outbreak in February 2024 with six residents and two staff were affected. All residents had recovered and while a post outbreak review had been completed it was not robust as it did not detail a quality improvement plan.

Some good practices were observed in respect of infection control for example the use of colour coded cloths and cleaning checklists. Residents' personal clothing and other laundry is transported to the group's facilities for laundering and is returned on a daily basis. There is one washing machine on-site in a kitchenette and this was being used by a resident who wished to launder their own personal clothing.

There was a comprehensive Infection prevention and control policy available. Staff had received training on the "skip the dip" campaign which aimed to prevent the inappropriate use of dipstick urine testing that can lead to unnecessary antibiotic prescribing which does not benefit the resident and may cause harm including antibiotic resistance. However, discussions with staff during the inspection found that this initiative and their infection prevention and control policy had not been embedded in practice. Findings are outlined under regulation 27;Infection control.

The registered provider had not ensured that the premises conformed to a number of matters set out in Schedule 6 of the regulations. The inspectors' findings are discussed under Regulation 17: Premises.

While improvements were noted in care planning, further action was required to ensure that adequate detail was contained in care plans to guide care delivery.

Required improvements in relation to assessment and care planning are discussed in more detail under regulation 5 of this report.

Regulation 17: Premises

The registered provider failed to ensure that the premises conformed to the matters set out in Schedule 6 of the regulations. This was evidenced by:

- There were signs of water ingress on a ceiling in a resident's bedroom. This was a repeated finding from a previous inspection.
- There was a broken ceiling tile and in some parts of the centre there were numerous holes through ceilings and walls that required sealing up.
- Access to a television in a residents' twin bedroom was only afforded to one resident, the walls were damaged and required painting.
- There was no secure enclosed garden space that residents could use. Instead an evacuation route was the only available outside space available to residents.
- Some doors and door frames had signs of damage. This was a repeated finding from a previous inspection.
- Residents were observed to be using an area outside the main front door as a smoking area. In addition staff were using a non designated smoking room. Both of these smoking areas were not included on the centre's statement of purpose.
- A significant amount of personal belongings of deceased residents were being stored in the designated centre.
- Inappropriate storage of residents belongings, hoist slings, torn mattresses and two irons were inappropriately stored in the physio room.
- There was a lack of hot water at a cleaners sink and at a sink located along a corridor when tested by the inspectors. Therefore, inspectors were not assured adequate hot water was being provided throughout the designated centre to meet residents needs.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider was failing to meet the regulatory requirements on fire precautions in the centre and had not ensured that residents were protected from the risk of fire. The provider was non-compliant with the regulations in the following areas:

Day-to-day arrangements in place in the centre did not provide adequate precautions against the risk of fire. For example:

On the first day of the inspection the provider was issued with immediate actions and urgent compliance plans due to inadequate fire precautions in regards to;

- Inappropriate storage practices were found in relation to flammable and combustible items. Large quantities of cardboard boxes and paint buckets were found in the store room. In a boiler room, large quantities of timber and machinery were noted.
- In a lift machine room, cardboard boxes were found to be stored and a plastic bag of discarded rubbish was found in an unauthorized staff smoking area.

The provider had de-cluttered and removed all items from these rooms by the second day of the inspection.

In addition to the above, the following fire risks were identified.

- Kitchen fire doors were found to be wedged open on both days of the inspection. This interfered with the closing mechanisms and would result in the easy passage of smoke and fire in the event of a fire.
- Fire extinguishers were not fitted at designated locations as indicated by signage on display.
- The inspectors were not assured the gas shut –off valve was connected to the fire detection alarm system and there was a lack of signage to indicate the location of gas shut off valve.

The provider did not provide adequate means of escape including emergency lighting. For example:

A store room labelled as a Shop was fitted with a non-fire rated glazed hatch which compromised the adjacent escape route. The inspectors could not be assured a timber ceiling in a church and mortuary/fire exit route would meet the required fire rating. This could potentially compromise the means of escape from this area in the event of a fire.

A keylock and two slide bolts were observed to be fitted to a fire exit. A Key was not fitted beside the door. This created a risk of a delayed egress in the event of a fire. An Internal window of a bedroom was located within a tunnel. The tunnel was used as a protected escape route in the event of a fire. However, the inspector was not assured the internal window would meet the required fire rating to contain a fire from spreading into the escape route.

Emergency exit signage was observed to be lacking in some areas of the centre to indicate clear escape routes in the event of a fire emergency. Externally, there was a Lack of emergency lighting to some external evacuation routes leading to fire assembly points.

A final fire exit from a protected staircase lead to external steps. This meant staff and residents would have to be evacuated up external steps in order to reach a fire assembly point. Staff did not use this fire exit. However signage present at the door indicated a fire exit and if staff followed the signage to the wrong door their evacuation would be impeded. Instead staff bypassed this fire exit and re-entered a corridor that lead to a final fire exit. This created a risk to residents being evacuated through an area that may be unsafe as residents would be re-entering the building instead of using the final exit within the protected staircase to escape through. This required a review.

In addition to this, the width of another protected escape staircase narrowed to 830mm. This was below the minimum required width and may be difficult to evacuate residents in the event of a fire.

The provider did not adequately maintain the means of escape and building fabric. For example:

Some corridors were found to be cluttered with trolleys which obstructed the means of escape. Numerous holes were found around penetrations through walls and ceilings that required fire sealing. These were found in a store room, the kitchen area, an electrical room, a utility store and in a staff smoking room for example.

In regards to fire doors, gaps were found at the bottom and side of fire doors. Smoke seals were found throughout to be painted over which resulted in them being ineffective. Screws were found to be missing to fire door hinges and non-fire rated ironmongery was found throughout. Furthermore, some fire doors would not close fully when tested and some fire doors were missing door closers. In addition to this, gaps were found between some fire door frames and structural opening were not appropriately fire sealed.

The registered provider had failed to adequately review fire precautions throughout the centre. For example:

A Fire Safety Risk Assessment previously carried out by the provider did not assess compartmentation or fire safety management. Therefore, it was not a fulsome and comprehensive assessment of the centre in regards to fire safety.

The providers' in-house checks had not identified Immediate and urgent actions in regards to fire risks that had to be issued to the provider on the day of the inspection.

The registered provider did not ensure by means of fire safety management and fire drills at suitable intervals, that the persons working in the designated centre and, in so far is reasonably practical, residents are aware of the procedures to be followed in the case of fire. For example:

A review of the fire training content and evacuation procedures did not assure the inspectors that these were centre specific to the centre. This was further compounded from speaking to staff, some of whom were unsure of the evacuation procedures from certain areas of the centre and the use of fire exits from protected

staircases. This required a review to ensure evacuation routes had been tested and staff were certain on the escape routes to be used in the event of a fire.

The registered provider did not make adequate arrangements for containing fires. For example:

From a visual inspection of the attic space, the inspectors were not assured there was adequate compartmentation measures provided both vertically and horizontally. A 60 minute compartment boundary was indicated on the floor plans. However, the compartment wall did not appear to be present in the attic space. Furthermore, Insulation had been removed from areas that reduced the fire integrity of the ceiling and holes were found through the attic into the 2nd floor.

Storage room walls on the 2nd floor were not built to full height and closers were not fitted to the fire doors. Some compartment boundaries appeared to have 30 minute fire resistant fire doors fitted instead of the required 60 minute fire doors. Gaps were found to compartment doors, kitchen doors. Smoke seals were missing from kitchen doors and some of the compartment doors.

The inspectors were not assured by the glazing and timber walls to the protected staircases in regards to would the fire rating required. The fire rating of the glazing or timber panelling could be verified.

The designated centre is connected to a separate building via an enclosed tunnel link. The link is used as an escape route for both buildings. There was no clear sign that adequate compartmentation was provided to separate the two buildings from each other in the event of a fire. Furthermore, the alarm system of designated centre was not linked to the adjoining building. This created a risk of a fire occurring in either one of the buildings without the occupants being alerted. Furthermore, there was no procedure in place if a fire did occur in the adjoining building.

Arrangements for evacuating all persons in the designated centre and safe placement of residents in the event of a fire emergency in the centre were not adequate. For example:

The inspectors were informed that the maximum number of staff required to aid in the evacuation of residents were two staff members. However, it was evident from speaking with staff and reviewing residents' evacuation requirements that a number of residents, one in particular located on the first floor, required additional staff to aid in their evacuation. This was not accurately reflected in the residents' evacuation requirements.

Taking into account; the layout of the centre is over a number of floors, the location of residents on the upper floors who required additional staff in an evacuation, the inaccurate evacuation requirements and the current staffing resources on duty at night time created a significant risk to the residents' safety and current measures in place to safety evacuate them in the event of a fire. This required a review to ensure measures were in place to ensure the safety of residents' in the event of a fire.

In addition to this, the simulated evacuation drill submitted post the inspection indicated a total evacuation time of 15 minutes to evacuate 8 residents from a compartment of 10 registered beds. This extended time for the evacuation of a fire compartment would imply a deficit in the evacuation strategy. As such the inspectors were not assured there were enough staff with the required skills and competence on duty at all times to safely evacuate residents in a timely manner. This required further review in order to ensure residents could be evacuated in a safe and timely manner.

It is acknowledged the provider did add an additional staff member on duty and resubmitted a fire drill with an improved time. However, further improvements were still required to reduce the time of evacuation to a reasonable and safe level.

The displayed procedures to be followed in the event of a fire required a review by the provider. For example:

Floor plans on display did not indicate the location of call points or the location of fire extinguishers. Fire action notices were lacking throughout the centre and were not displayed beside the fire panel. Action notices that were displayed were too detailed, too small to read and were displayed in an area with other notices that would cause confusion and delay for staff to refer to in the event of a fire. In addition to this, the floor plans did not indicate a lobby fire door at a bedroom. As such, floor plans and fire action notices require a review.

Judgment: Not compliant

Regulation 27: Infection control

The registered provider did not ensure that procedures consistent with the National Standards for Infection Prevention and Control in Community Services (2018) published by the Authority, were implemented. For example;

- There was a continued reliance on the use of dipstick urinalysis for assessing evidence of urinary tract infection. This was contrary to national guidelines which advise that inappropriate use of dipstick testing can lead to unnecessary antibiotic prescribing which does not benefit the resident and may cause harm including antibiotic resistance. Six residents routinely had dipstick urinalysis taken on Sundays.
- Rooms ready for occupation were not clean. Some pillows and mattress covers were observed to be damaged and could not be cleaned therefore increasing the risk of infection.
- There was inappropriate storage of continence wear on the floor of a toilet. This creates a risk of cross-contamination.
- Some equipment for use by residents was observed to be unclean for example stained urinals and small number of unclean commodes.

- Linen trolleys were not covered when transporting clean linen, this was addressed on day two of inspection.
- The smoking room and fans were not clean on day one and were not on cleaning checklists. Both were addressed on day two.
- Clinical waste was not disposed off appropriately, an immediate action was issued. This was immediately actioned.
- The provider had introduced a tagging system to identify equipment that had been cleaned. However, this system had not been consistently implemented at the time of inspection. For example, some items of shared equipment had not been tagged after cleaning and the tag was not removed after using some equipment. Further training was required to ensure effective implementation of the system.
- Some of the residents sinks provided did not meet the recommended specifications however the inspectors acknowledge there was an assessment of the sinks provided planned.
- Hoist slings in use were not always labelled for residents individual use. Inspectors found two slings in a room which did not belong to the residents occupying this room. This practice created a risk of cross contamination.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Some improvements were required to comply with regulation 5 assessment and care planning This was evidenced by:

- adequate detail was not contained in a care plan of a resident with a urinary catheter (catheter in place to drain the bladder)to clearly direct staff on this resident's care needs.
- adequate detail was not included in two care plans for residents with urinary catheter to evaluate their intake and output. This meant that if an increase or decrease in intake was required, it was not identified without delay and appropriately actioned.
- the personal evacuation care plans for four residents were not accurate and required urgent review.
- one resident assessed needs, required an additional 19 hours care hours weekly, this was suspended in April. While the provider was trying to recommence this care plan ,no interim arrangements were made. As a result this resident's social care plan was limited.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 23: Governance and management	Not compliant
Regulation 15: Staffing	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant

Compliance Plan for Our Lady's Manor Nursing Home OSV-0004632

Inspection ID: MON-0042682

Date of inspection: 16/05/2024

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Additional staffing resources have been allocated to the Centre as follows:

1) An additional HCA is rostered for night-duty and this will be continued pending the conclusion of a fire safety risk assessment by a chartered engineer and the completion of fire safety works.
2) Two housekeepers are now rostered at weekends.
3) A third staff nurse has been rostered from 08:00 until 14:00 to meet the assessed needs of the residents. This will be kept under review.
4) We have advertised for a part-time activities staff member which will allow us to roster an activities person each weekend once recruited.

A comprehensive fire safety risk assessment by a chartered engineer is currently underway. Some immediate works have been carried out in the attic space to maintain effective compartmentalisation. New fire doors are being installed at various locations in the Centre. Further work will be required as identified in the fire safety risk assessment. This fire safety risk assessment will be sent to the Chief Inspector by the 30th September 2024 at the latest.

Fire signage has been reviewed and replaced as necessary.

Further fire drills have been carried out in various parts of the Centre. PEEPs have been reviewed and updated in conjunction with those drills. Learning from those drills has been implemented.

Our system of fire safety checks is being reviewed as part of the fire safety risk assessment.

An IPC audit has been carried out and learning from that audit has been implemented. Actions outlined under Regulation 27 are being / have been carried out.

An external TVN has undertaken a review of wounds in the Centre. The nursing team are implementing her recommendations.

Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
Additional staffing resources have been allocated to the Centre as follows:

1) An additional HCA is rostered for night-duty and this will be continued pending the conclusion of a fire safety risk assessment by a chartered engineer and the completion of fire safety works.
2) Two housekeepers are now rostered at weekends.
3) A third staff nurse has been rostered from 08:00 until 14:00 to meet the assessed needs of the residents. This will be kept under review.

The current activities team has been reviewed. A new activity plan is being organised to meet residents needs at weekends.

We have advertised for a part-time activities staff member which will allow us to roster an activities person each weekend once recruited.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The ceiling in a resident's bedroom has been painted. The leak that caused the ingress of water was repaired.

We are sourcing replacement ceiling tiles, and any broken ones will be replaced.

Penetrations in compartments are being assessed as part of the fire safety risk assessment. We have retained a company to carry out fire sealing.

An additional TV has been purchased for the twin room.

Increased maintenance hours have been provided to allow for redecoration of the

Centre.

Plans have been made for a secure garden. Construction work on this will start shortly.

Staff have ceased using an area which was not designated as a smoking area. Staff must now leave the Centre if they wish to smoke.

In line with our policy, "Management of Residents Property Personal Finances and Possessions", after death possessions will be kept for a reasonable timeframe for collection. After such time they will be donated to charity.

The physio room has been decluttered.

A plumber has checked the hot water supply to sinks in the Centre. Some taps have now been replaced.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: A comprehensive fire safety risk assessment by a chartered engineer is currently underway. Some immediate works have been carried out in the attic space to maintain effective compartmentalisation. New fire doors are being installed at various locations in the Centre. Further work will be required, if identified in the fire safety risk assessment. This fire safety risk assessment will be sent to the Chief Inspector by the 30th September 2024 at the latest.

Works that have been carried out as of 5th August 2024 include:

1) Fire signage has been reviewed and replaced as necessary.
2) Kitchen doors are no longer being wedged open. New door closers will be fitted to allow them to stay open safely and close when the fire alarm activates.
3) Fire extinguishers are now in the hairdresser's room.
4) The gas shut-off valve will now close upon the activation of the fire alarm. Signage is in place to indicate its location.
5) Emergency exit signage has been reviewed and replaced where necessary.
6) Additional emergency lighting has been installed.
7) A fire break has been built in the attic space.

Fire doors have been ordered and confirmation received from the supplier that work will commence on the 19th August 2024. This work also includes upgrading existing fire doors where deficits have been identified. It will take approximately one week to complete the work.

Penetrations in compartments are being assessed as part of the fire safety risk assessment. We have retained a company to carry out fire sealing.

Further fire drills have been carried out in various parts of the Centre. PEEPs have been reviewed and updated in conjunction with those drills. Learning from those drills has been implemented. We have also updated our training as a result of these drills.

Our system of fire safety checks is being reviewed as part of the fire safety risk assessment.

The other items specifically identified in the Inspectors' report will be assessed as part of the fire safety risk assessment. An action plan to identify any deficits will be drawn up and delivered to the Chief Inspector by the 30th September 2024.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

• All nurses are informed of the National Guidelines (Skip The Dip) via poster, information folder and team meetings. Residents are not now having dipstick urinalysis taken routinely. Assessment for UTI is being based on clinical signs and symptoms and in consultation with resident GP's.
• Rooms ready for occupation have been deep cleaned. Some pillows and mattress covers have been replaced.
• Continence wear has been removed from floors. It is now being stored in residents' lockers/wardrobes.
• All resident equipment is being cleaned after each use. New urinals have replaced any old, stained ones.
• A covered linen trolley has been ordered.
• The non-designated staff smoking room is no longer in use.
• Fans are now on cleaning checklists.
• Clinical waste is being disposed in clinical waste locked bins.
• Reinforced with staff about how the tagging system is to identify equipment that has been cleaned. The tag is to be removed after using an item of equipment.
• Residents' sinks are being reviewed to ensure they meet the specified requirements. They will be upgraded as required.
• All residents are using individual labelled slings to prevent cross contamination.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

• All care plans in place for urinary catheters has been reviewed to direct the staff on the residents' detailed care needs, to observe and evaluate resident intake and output, to be able to act accordingly without delay in the event a residents' condition changes.
• Nurses have attended care plan training on 20/06/2024 and 27/06/2024.
• All PEEPs have been evaluated and updated accordingly.
• Arrangements has been put in place for the resident that required additional hours of care weekly. A new PA has been appointed by the HSE with effect from 31st May 2024.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	06/08/2024
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/01/2025
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the	Not Compliant	Orange	30/09/2024

	effective delivery of care in accordance with the statement of purpose.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/09/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	30/09/2024
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Red	30/09/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape,	Not Compliant	Orange	31/01/2025

	including emergency lighting.			
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	31/01/2025
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/09/2024
Regulation 28(1)(d)	The registered provider shall 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.	Not Compliant	Orange	30/09/2024
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety	Not Compliant	Red	30/09/2024

	management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	30/09/2024
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Red	30/09/2024
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Substantially Compliant	Yellow	06/08/2024
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs	Substantially Compliant	Yellow	06/08/2024

	of each resident when these have been assessed in accordance with paragraph (2).			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	06/08/2024