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:	Gowran Abbey Nursing Home
Name of provider:	Gowran Abbey Nursing Home Limited
Address of centre:	Gowran Abbey Nursing Home Limited, Abbey Court, Gowran, Kilkenny
Type of inspection:	Unannounced
Date of inspection:	10 October 2024
Centre ID:	OSV-0000232
Fieldwork ID:	MON-0044863

About the designated centre

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

Gowran Abbey Nursing Home is a purpose-built single-storey building that first opened in 2007. It consists of 51 single ensuite bedrooms. The provider is Gowran Abbey Nursing Home Limited. The centre is located on the outskirts of Gowran village, Co Kilkenny situated in a quiet cul-de-sac among 10 retirement houses for independent living. The location is convenient for access to the GP surgery, pharmacy, post office and shop. The centre provides care and support for both female and male adult residents usually aged 50 years and over requiring long-term care with low, medium, high and maximum dependency levels. Persons under the age of 50 years may be accommodated following assessment of individual care needs to ensure that the centre is suitable to provide for the needs of the individual, and that there is no adverse impact on them or other residents. The centre aims to provide a quality of life for residents that is appropriate, stimulating and meaningful. Pre-admission assessments are completed to assess a potential resident's needs to ensure the centre can cater for each individuals' needs. The centre currently employs approximately 64 staff and there is 24-hour care and support provided by registered nursing and healthcare assistant staff with the support of housekeeping, catering, administration, laundry and maintenance staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	49

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 10 October 2024	08:45hrs to 18:00hrs	Aisling Coffey	Lead
Thursday 10 October 2024	08:45hrs to 18:00hrs	Niall Whelton	Support

What residents told us and what inspectors observed

The overall feedback from residents who spoke with the inspectors was that they were happy and liked living in Gowran Abbey Nursing Home. The majority of residents spoken with were highly complimentary of the centre and the care they received, with one resident describing the centre as "a home from home" while another resident told inspectors they were "treated very well". When it came to the staff that cared for them, residents told the inspectors about the "lovely women" who looked after them and how the staff had "great patience". There was high praise for the activities programme and activity staff members. Residents told the inspectors how they enjoyed card games, board games, bingo, singing, painting and arts and crafts. Two residents informed the inspector they were unhappy with certain aspects of the service provided, and these matters were referred to nurse management on inspection day. Overall, the resident feedback captured the person-centred approach to care and attention provided in this centre, where residents were supported to have a good quality of life by a highly dedicated staff team. The inspectors observed warm, kind, dignified and respectful interactions with residents throughout the day by all staff and management. Staff were knowledgeable about the residents' needs, and it was clear that staff and management promoted and respected the rights and choices of residents living in the centre.

Two inspectors of social services conducted this unannounced inspection, which took place over one day. During the inspection, the inspectors chatted with many residents and had the opportunity to speak in more detail to 14 residents to gain insight into the residents' lived experience in the centre. The inspectors also spent time observing interactions between staff and residents and reviewing a range of documentation.

The centre is a large single-storey premises in a quiet cul-de-sac. Upon entering the centre, the entrance foyer and waiting area were attractive and welcoming, with comfortable furnishings, decorative features, and information on available services. Residents and visitors were seen to use this area throughout the day.

Elsewhere, the centre was pleasantly decorated throughout, with paintings and photographs of residents and staff enjoying group activities displayed. The centre was also in the process of being redecorated on the day of inspection, with painting observed to be taking place.

The centre's design and layout supported residents in moving throughout the centre, with wide corridors and sufficient handrails to accommodate residents with mobility aids. There were multiple communal areas for residents to enjoy, including a living room and adjoining dining room, an activities room, a prayer room, and a newly decorated quiet room. The rest area outside bedroom 28, which had previously been used for equipment storage, was observed to be converted back to a comfortable seating area for residents. Some rooms in the centre were seen to have changed purpose since the last inspection, including the assisted bathroom,

which was now being used to store hoists and oxygen. The bath previously within the assisted bathroom had been removed, reducing available options for residents who could not use a shower facility. A toilet facility had been converted to a sluice room, and new external storage, in the form of a log cabin, had been installed since the last inspection.

There was an onsite laundry service where residents' personal clothing was laundered. This area was seen to be clean and tidy, and its layout facilitated the functional separation of the clean and dirty phases of the laundering process. All residents and visitors spoken with were satisfied with the laundry service provided.

Bedroom accommodation consisted of 51 single bedrooms with en-suite shower, toilet, and wash hand basin facilities. The temperature within each bedroom was thermostatically controlled. Bedrooms had comfortable seating and were personalised with family photographs and items from home, such as paintings, bedding and ornaments. Bedrooms had a television, locked storage and call bell facilities. Residents whom the inspectors spoke with were pleased with their bedrooms and personal space. The inspectors noted that the provider had replaced the damaged flooring seen within some resident bedrooms on the last inspection.

The centre's two internal courtyard gardens were clean, tidy, and pleasantly decorated. Both areas had paving works completed since the last inspection. These courtyards had comfortable seating, garden decorations, water features, raised flower beds, potted plants and flowers. Externally, the centre's grounds were also clean, tidy and well-maintained.

On the morning of the inspection, residents were up and dressed in their preferred attire and appeared well cared for. The centre had an activities programme which took place over seven days. A varied programme of activities was available. On inspection day, the living room was a hive of activity and laughter throughout the day. The inspectors observed group-based activities, including discussion of current affairs, bingo, quizzes, and wheel of fortune. One resident proudly told the inspectors that he had won the wheel of fortune and, in turn, had acquired 15 "gobbies". The resident explained to the inspector that these "gobbies" were used as a currency to purchase prizes later in the month.

Several residents relaxed in their bedrooms in accordance with their preferences. These residents were seen watching television, listening to the radio, reading newspapers and books, writing in their diaries or using their laptops and the centre's internet services. All residents who spoke to the inspectors expressed high praise for the activities programme and entertainment available.

Residents had access to radios, televisions, newspapers and internet services. There were arrangements in place for residents to access independent advocacy services. Roman Catholic Mass was celebrated in the centre on a Wednesday. Outside of mass, the centre's prayer room provided a space for prayer and quiet reflection.

Visitors were observed coming and going throughout the day, spending time with their loved ones in the multiple comfortable communal areas. Residents confirmed there were no restrictions on visiting.

Lunchtime at 12:30pm was a sociable experience, with most residents eating in the dining room. Meals were freshly prepared in the centre's onsite kitchen. The menu, with two main courses and dessert options, was displayed in the dining room. Residents confirmed they were offered a choice of main meal and dessert. A resident with specialist dietary requirements informed the inspector their requirements were facilitated. The food served appeared nutritious and appetising. There were ample drinks available for residents at mealtimes and further drinks accompanied by snacks throughout the day. Most residents expressed their satisfaction to the inspectors about food quality, quantity and variety. At the same time, a minority were more neutral in their response, describing the food as "ok" and "up and down".

While the centre was generally clean, staff practices cleaning the dining room, managing storage, and decontaminating resident equipment required review, as outlined under Regulation 27: Infection control.

The following two sections of the report present the findings of this inspection concerning governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

Overall, this was a well-governed centre with good systems to monitor the quality of care provided to residents. It was evident that the centre's management and staff focused on providing quality services to residents and promoting their well-being. While established management systems were in place, some actions were required to ensure all areas of the service met the requirements of the regulations.

This was an unannounced inspection to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and review the registered provider's compliance plan from the previous inspection of 20 February 2024. The registered provider progressed with the compliance plan, and improvements were identified in many areas, including premises, infection control procedures, contracts for the provision of services and notification of incidents. Following this inspection, further actions were required concerning a number of regulations as set out in this report.

Gowran Abbey Nursing Home is a privately owned nursing home. The registered provider is Gowran Abbey Nursing Home Limited. At the time of inspection, there were four directors in this company, one of whom represented the provider for

regulatory matters and was present on the day of inspection and for feedback at the end of the inspection. The person in charge reported to the board, worked full time in the centre and was supported by an assistant director of nursing and a team of nursing, healthcare assistants, an activity coordinator, chefs, catering, housekeeping, laundry, maintenance and administration staff.

The provider had management systems to monitor the quality and safety of service provision. These systems included clinical governance and staff meetings where quality and safety were the focus. This was evidenced by minutes of both senior management and staff meetings. A comprehensive audit schedule examined call bell response times, falls, residents' weights, antibiotic usage, wound care, restraint usage and infection control. These audits identified deficits and risks in the service and had time-bound quality improvement plans to enhance resident safety. The provider also monitored monthly key performance indicators in similar areas, including wound care, falls and restraint usage. The provider had a system to oversee accidents and incidents within the centre. Incidents, as set out in Schedule 4 of the regulations, were notified to the Chief Inspector of Social Services within the required time frames. Records reviewed found that incidents like falls were being analysed to identify trends and causal factors.

Notwithstanding this good practice, this inspection found that some areas of governance and oversight needed to be more robust to effectively identify deficits and risks in the service and drive quality improvement. For example, the governance and oversight of fire safety were not aligned with the centre's fire safety management plan. This plan included a fire safety risk assessment, which was to be completed by a fire safety professional to identify hazards and evaluate fire safety risks in the centre. At the time of this inspection, the fire safety risk assessment had not been carried out. These matters will be discussed under Regulation 23: Governance and management.

The provider had completed the annual review of the quality and safety of care delivered to residents for 2023. The inspectors saw evidence of the consultation with residents reflected in the review.

The provider had sufficient staff on duty to meet the assessed needs of residents. Staff spoken with were clear about roles and responsibilities. The records reviewed found staff had access to training to support them in their roles and were appropriately supervised. The provider had a comprehensive suite of policies and procedures to guide staff practice as required by the regulations. Residents were seen to have a contract for the provision of services that met the requirements of the regulation.

The inspector sought to review the directory of residents and found that while the directory held the majority of the required information, including date of birth, home address, admission date, and general practitioner details, there were a small number of gaps when residents were transferred to the hospital. This will be discussed under Regulation 19: Directory of Residents.

Regulation 15: Staffing

Based on a review of the worked and planned rosters and from speaking with residents and visitors, sufficient staff of an appropriate skill mix were on duty each day to meet the assessed needs of the residents. Two registered nurses were working in the centre at night.

Judgment: Compliant

Regulation 16: Training and staff development

There was evidence that newly recruited staff had received an induction covering key aspects of care and procedures in the centre, including health and safety, fire safety, infection control, policies and records management. This induction was followed by a probationary period under which the employee's performance was monitored and reviewed by their line manager.

Staff had access to training appropriate to their role. A system for tracking staff training and records was made available to the inspectors, demonstrating that all staff were up-to-date with mandatory training in fire safety, manual handling, infection control, managing challenging behaviour, and safeguarding vulnerable adults from abuse.

Staff were appropriately supervised and clear about their roles and responsibilities.

Judgment: Compliant

Regulation 19: Directory of residents

While the centre had an electronic register of residents, this directory did not record all the information required under Schedule 3 of the regulations. For example, when residents were transferred to a hospital, the name of the hospital and the date on which the resident was transferred were not recorded for all transfers.

Judgment: Substantially compliant

Regulation 23: Governance and management

While the registered provider had several assurance systems in place to monitor the quality and safety of the service provided, improvements were required to governance and management to ensure that the service provided was safe, appropriate, consistent and effectively monitored. For example:

- Further robust oversight was required in the management of fire safety. The monitoring systems in place had not adequately ensured that all necessary precautions were in place to protect residents in the event of a fire emergency. These matters will be discussed under Regulation 28: Fire Precautions.
- Infection prevention and control audits did not identify the gaps in cleaning practices, storage management, and decontaminating resident equipment noted during this inspection.
- The provider's risk management systems had not identified gaps in individual assessment and care planning and access to healthcare as found on this inspection.

The registered provider was in breach of Condition 1 of their registration as they had made changes to the purpose and function of a number of rooms. The provider had not informed the Chief Inspector and had not applied to vary condition 1 of the centre's registration. The changes made included the following:

- The assisted bathroom on the floorplans had changed function to a store room, and the only bath in the centre had been removed.
- A toilet on the floorplans had been converted into a sluice room.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Inspectors reviewed a sample of residents' contracts and found that they set out the allocated bedroom number and occupancy. The contracts outlined the service to be provided and the fees to be charged, as well as referencing other services the residents may choose to avail of for an additional cost, such as private physiotherapy.

Judgment: Compliant

Regulation 31: Notification of incidents

Arrangements for recording accidents and incidents were in place and were notified to the Office of the Chief Inspector as required by the regulations.

Judgment: Compliant

Regulation 4: Written policies and procedures

The policies required by Schedule 5 of the regulations were in place, updated in line with regulatory requirements and made available to staff in the centre.

Judgment: Compliant

Quality and safety

While the inspectors observed kind and compassionate staff treating the residents with dignity and respect, robust action was required concerning fire precautions to ensure that residents were appropriately protected from the risk of fire. Some further improvements were also required concerning individual assessment and care planning, healthcare, and infection control to ensure safe and effective care delivery.

The provider had processes to manage and oversee infection prevention and control practices within the centre. The centre's interior was generally clean on the inspection day, and there were records of cleaning schedules. Surveillance of healthcare-associated infections, multi-drug resistant organism colonisation and the volume of antibiotic usage were undertaken and recorded. The centre had conveniently located hand hygiene sinks, and staff members were observed to have good hand hygiene practices. Notwithstanding these good practices, some areas for improvement were identified to ensure compliance with the National Standards for Infection Prevention and Control in Community Services (2018), as discussed under Regulation 27.

The inspectors reviewed the physical environment, the fire safety systems in place and fire safety management. In general, inspectors found that the centre was laid out in a manner that provided an adequate number of escape routes and fire exits. Each bedroom corridor had escape in both directions, one of which led directly to the outside. Externally, escape routes were sufficient to allow escape out and away from the building. There was signage leading towards an assembly point, however, the assembly point itself was not provided with signage.

Following the previous inspection, the provider arranged for a review of 13 cross-corridor doors, for which a draft report was issued; the provider was awaiting the final report. Each of these doors was fitted with a tag which identified the rating of the door and the date when they were inspected. At this inspection, the provider also confirmed that a final report of the remaining doors in the centre would be subsequently issued.

The fire alarm system had been upgraded within the last two years. Fire doors throughout the centre were fitted with a device that allows the resident to safely keep their door open; this device would automatically close the door on activation of the fire alarm system.

Notwithstanding the favourable layout of the centre and actions taken thus far, it was not clear during the inspection as to the fire compartment strategy and fire containment measures in the attic areas, including the ceiling throughout. Further action was required by the provider to address fire safety risks; these are discussed under Regulation 28.

The person in charge had arrangements for assessing residents before admission into the centre. The inspector reviewed comprehensive person-centred care plans based on validated risk assessment tools. There was documentary evidence of resident and family consultation when care plans were reviewed. Notwithstanding these areas of good practice in care planning, some gaps were observed, which will be outlined under Regulation 5: Individual assessment and care plan.

The health of residents was promoted through ongoing medical review and access to a range of external community and outpatient-based healthcare providers such as chiropodists, dietitians, physiotherapy, speech and language therapy and mental health services. Notwithstanding this good practice, the inspector found that some action was required to ensure residents had access to additional professional expertise. This will be discussed under Regulation 6: Healthcare.

Regulation 11: Visits

The inspector observed that visits to the centre were encouraged. The visiting arrangements in place did not pose any unnecessary restrictions on residents. The registered provider had suitable private visiting areas for residents to receive a visitor if required.

Judgment: Compliant

Regulation 12: Personal possessions

Residents were supported in accessing and retaining control over their personal property and possessions. Residents had adequate space to store and maintain their clothing and possessions. Residents had access to lockable storage facilities in their bedrooms for valuables. The centre had a tidy, well-organised onsite laundry for laundering residents' clothing. The provider is not a pension agent for any residents.

Judgment: Compliant

Regulation 17: Premises

The internal and external premises were maintained to a good standard and maintenance personnel were onsite on inspection day attending to areas requiring painting. The centre's design and layout were suitable for its stated purpose and met residents' individual and collective needs in a homely way that promoted independence. Residents had access to two pleasant and secure internal courtyard garden areas, accessible from various parts of the centre.

Judgment: Compliant

Regulation 27: Infection control

While the provider had processes in place to manage and oversee infection prevention and control practices within the centre, and the environment was generally clean and tidy, some areas required attention to ensure residents were protected from infection and to comply with the National Standards for Infection Prevention and Control in Community Services (2018).

The oversight of staff cleaning practices in the residents' dining room required review, for example:

- Storage drawers and cupboards for crockery and utensils were visibly dirty with loose food, debris and dried-in liquid stains.
- Some resident crockery was unclean with dried-in liquid stains.

The decontamination of resident care equipment required review, for example:

- Two crash mats were observed to be visibly dirty with staining and other debris. Furthermore, one of the crash mats was torn, preventing effective cleaning.

Some storage practices posing a risk of cross-contamination required review; for example, vases were being stored in the sluice room.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The inspectors were not assured that the registered provider had taken all reasonable actions to ensure that residents were appropriately protected from the risk of fire. Under this regulation, immediate action was required by the provider to address two urgent risks:

- There was inappropriate storage within the electrical room, including a petrol lawnmower, combustible cardboard and two bottles of white spirits.
- The inspectors observed two beds that did not have evacuation aids fitted beneath the mattress in line with the evacuation strategy. One of the residents had high dependency care needs, and the personal emergency evacuation plan (PEEP) for that resident indicated that a ski sheet was required for evacuation.

The manner in which the provider responded to the risks provided assurance that the risks were adequately addressed.

In addition to the above, the provider was not taking adequate precautions against the risk of fire, nor adequately reviewing fire precautions, for example:

- There was an electronic tablet left on charge; the plug was in a linen closet adjacent to combustible linen, creating a risk of fire. This was on a corridor with residents' bedrooms.
- Oxygen cylinders were temporarily moved into a store room with mobility hoists with batteries on charge, creating a risk of escalating a fire if one started.

Arrangements for detecting and containing fire in the designated centre required improvement. For example:

- There was a lack of clarity regarding the size and extent of fire compartment boundaries. The evacuation strategy in the centre was progressive horizontal evacuation, which means assisting residents from the area where a fire starts through to the next fire compartment. From the information available, it appears the building is divided into two compartments of 25 and 26 resident bedrooms respectively. One of the compartment boundaries appeared to separate the dining room from the living room. The door from the dining into the living room was not considered a fire door by the provider as it was routinely left open and, from visual inspection, was not an effective fire door. During the inspection, there was reference to further sub-compartments, but it was not known if the attic above these walls and doors was subdivided to match the line of the compartment below; these sub-compartment boundaries were of a lower fire resistance. The provider committed to getting the fire compartment boundaries reviewed to determine the correct boundaries to inform correct evacuation procedures.
- The laundry enclosure had been extended into an adjacent former cleaning room, and further assurance was required regarding fire containment to the laundry room enclosure.
- The inspectors noted a number of penetrations through the fire-rated ceiling throughout the building for recessed lights, attic hatches, wiring, mechanical

extract fans, and ductwork. Further assurance is required that appropriate fire sealing and/or proprietary products were used to maintain the effectiveness of the fire-rated ceiling.
- While fire doors were provided throughout, the inspectors observed a number of fire doors that were not fitted with smoke seals.
- There was an excessive gap at the bottom of a fire door to a store room.
- In a number of areas, the door provided was not of a sufficient rating to ensure adequate containment of fire. For example, the doors to the laundry room were thirty-minute fire-rated doors and not sixty-minute fire-rated doors. The compartment door between the living room and dining room was not an effective fire door.
- The activities store was not adequately fire separated from a service press containing electrical fuse boards.
- There was a lack of clarity regarding the fire detection and alarm system. The annual certificate for servicing the system indicated it to be an L3 type system; nursing home use requires an L1 fire detection and alarm system, which relates to the areas covered by fire detection.
- Where rooms had changed function, assurance was required that the correct annotation of the location of the activation appeared on the fire alarm panel.
- In the 'Tir na Nog' Quiet Room, a former smoking room, the heat detector was still in place and had not been changed to a smoke detector when the room's purpose changed. A smoke detector provides an earlier warning of fire than a heat detector.

Arrangements for providing adequate means of escape, including emergency lighting, required improvement. For example:

- Externally, the inspectors were not assured that suitable emergency lighting was provided along some external routes to illuminate the route of escape in the event of a fire evacuation, particularly at night time.
- The external routes along the southeast side of the building led through a gate. There was an open padlock on the gate, however, from the side of escape it was out of reach to remove it to open the gate, even though it was not locked.

Arrangements for maintaining fire equipment, means of escape, building fabric and building services required improvement:

- Not all records for the fire safety systems were available for review; the quarterly reports for the fire alarm system were not available.
- The fastening to the exit adjacent to bedroom 2 required action as it was getting caught by the ground when opened.
- There was no periodic inspection report to demonstrate that the fixed wire electrical installation had been inspected and tested.

Arrangements for evacuating all persons in the designated centre and safe placement of residents in the event of a fire required improvement:

- While all staff had attended fire safety training, there were some mixed responses from staff regarding the evacuation strategy. Staff spoken with understood the concept of the evacuation strategy; however, there was confusion as to which corridor doors would be used during evacuation. Evacuation into the next fire compartment was the strategy; however, unknown fire compartment boundaries led to this confusion.
- Fire drills were being completed and included detailed information on how the drill went and learning outcomes. The drills reflected reduced staff levels at night time; however, they did not reflect potential compartment sizes. This may lead to residents being assisted to an area of the building which is not safe. Further assurance from the provider is required in relation to the integrity of fire compartment boundaries used to support progressive horizontal evacuation.
- The inspectors reviewed the personal emergency evacuation plans (PEEPs), which provided information on the evacuation needs of residents. There were inconsistent assessments; for example, two residents were assessed as requiring four staff to assist them to evacuate. When explored with the person in charge and staff, this was deemed to be inaccurate. There were also two PEEPs that had not been reviewed since May 2024, which did not align with the centre's fire safety management document.
- The lack of clarity regarding fire compartments resulted in unknown risks to residents in terms of the evacuation strategy in the centre.

The procedures to follow in the event of a fire were not prominently displayed in the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

While care records were seen to be person-centred and reflect residents' needs, some action was required concerning individual assessment and care plans to ensure the needs of each resident were comprehensively assessed and an appropriate care plan was prepared to meet these needs within the required regulatory time frames. For example:

- One resident, currently assessed at risk of malnutrition, did not have their malnutrition risk assessment completed until nine days after admission and their nutrition care plan completed until 15 days after admission, which is not in line with regulatory time frames.

Care plans were not always reviewed and updated following a change in the resident's condition or at four monthly intervals as required by the regulation, for example:

- One resident's care plans had not been reviewed at the required intervals to ensure that care was appropriate to the resident's changing needs. These care plans were seen to be reviewed over 10 weeks after the required timeframe.
- This same resident had fallen, and their mobility care plan was not updated until 9 days after they returned from the hospital.

Judgment: Substantially compliant

Regulation 6: Health care

Notwithstanding residents' access to a range of healthcare professionals, action was required to ensure that all residents had access to appropriate healthcare as outlined within their care plan prepared under Regulation 5. For example, the inspectors reviewed the records of three residents who had specialised seating with a lap belt. Notifications received by the Chief Inspector and the residents' care plans referred to the lap belts being used in accordance with the recommendations of an occupational therapist. However, in the three resident records reviewed by the inspectors, there were no specialist recommendations from an occupational therapist to guide nursing staff on the safe and correct usage of the lap belts.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The inspectors found that residents' rights were upheld in the centre. Staff were respectful and courteous towards residents. Residents had facilities for occupation and recreation and opportunities to participate in activities in accordance with their interests and capacities. Residents had the opportunity to be consulted about and participate in the organisation of the designated centre by participating in regular residents' meetings and completing residents' questionnaires. Residents' privacy and dignity were respected. The centre had weekly Roman Catholic religious services onsite. Residents could communicate freely and had access to telephones and internet services throughout the centre. Residents also had access to independent advocacy services.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Gowran Abbey Nursing Home OSV-0000232

Inspection ID: MON-0044863

Date of inspection: 10/10/2024

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 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: The Directory of Residents (a computerised Programme) has been reviewed and the IT Programmer has taken steps to ensure that all relevant information is carried automatically from Data completed in the National Transfer Form Information.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Regulation 23: Governance and management Not Compliant Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider has engaged and received compliance assurance and reports from independent fire safety companies over the past 12 - 18 months in relation to Fire Doors and the precautions in place in the event of fire. The Provider is assured by these experts that fire safety measures are regulatory compliant. Having sought and received this expert advice, we are confident that our monitoring systems adequately ensure that necessary precautions are in place and that we are compliant in this area. The Provider will continue to take the steps necessary to ensure that adequate precautions are in place to protect residents in the event of a fire.	

Further minor improvements are required, and these improvements have been substantially progressed with the replacement of cross-fire doors.
The Provider will continue to monitor, review and seek expert professional assurance in relation to all our Fire Safety Measures. Given conflicting judgements between the authority and our external experts, a further external review is due to take place in February 2025 after which time we will receive a further detailed external Fire Safety Report to assure the provider and the authority that fire safety doors are compliant.

Additional Infection Control Audits have been carried out since the latest inspection, gaps identified, and remedial measures implemented as appropriate.

Additional Audits of Assessment and Care- Planning have taken place and following review, the provider is assured that mechanisms are in place to identify gaps in both assessments and individual care plans.

Following issues identified at an inspection in February 2024, and inspector's judgements regarding non-compliance in relation to 'infection control and premises', an immediate internal risk assessment was undertaken which identified immediate interim remedial actions that should be implemented to ensure the safety of residents within the centre and enhance infection control. These suggestions were discussed with individual Residents and at Resident and Management Meetings during which agreement was expressed by residents and staff regarding suggested measures.

The Provider will apply to vary condition 1 of the Centre's registration on the basis that immediate work was considered necessary to achieve compliance and address inspection judgments.

Current residents in the nursing home have access to individual ensuite shower facilities and a shower slide if required.

The bathroom in the nursing home had not been utilised since 2013 - and a detailed risk assessment report including engagement with residents outlines the findings and rationale for the temporary removal of the unused bath.

In addition, the work required to achieve infection control and safety compliance necessitated that an alternative area for a bathroom and WC was identified which will not impact on any area or room utilised by residents and updated floor plans have been submitted to the Inspectorate.

Inspectors' judgements regarding the number of available sluice rooms and perceived impact on infection control measures in the centre were also given serious consideration by the Provider and timely measures taken to achieve compliance in this area. To achieve compliance, the relocation of a staff WC was necessary, which has enhanced infection control measures and the safety of residents and staff in the centre with no adverse impact on residents or staff.

An updated SOPS document was sent to the inspectorate in September 2024, and the Provider was not alerted by the inspection team that this had not been received. A copy

of the updated SOPS has subsequently been re-submitted

The services of an architect were engaged as stated, and due to the complexity of sourcing the original 2005 / 2006 plans and various changes in the business structure, the process took longer than anticipated. The provider has submitted updated floor plans to the Inspectorate.

In addition to this, the Plans have been submitted to an external Fire Safety Consultant who has been engaged to fully assess and identify compartmental areas and prepare updated evacuation and compartmentation Plans/Maps combined with another Fire Safety Assessment.

A draft copy of Compartment Plans has been submitted to the authority.

Notwithstanding these works, a Fire Safety Certificate issued by the relevant local (Kilkenny) authority exists and the Provider is assured that cognisance of fire safety in the centre is robust and will do all that is necessary to ensure it remains so.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Further audits of infection control, decontamination, cleaning practices and storage of equipment have taken place and remedial measures including re-education of staff has been implemented to ensure achievement of full compliance.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Further to discussion with our external Fire Safety experts and remedial work carried out, the Provider is advised and assured that our Fire Safety measures, and monitoring are robust.
An expert external report on all doors in the nursing home with mapping application is now available following a third review/inspection by our Fire Safety experts and has been submitted to the authority. This report assures the Provider of compliance.

• Remedial measures in relation to 2 x identified risks were implemented on the day of inspection and the Provider is assured appropriate further action was taken and staff re-educated.

• Our Electrical Contractor has re-postioned an electronic tablet charging point, however the Provider also noted this was not in an used cupboard.
• Oxygen Cylinders temporarily stored during painting/maintenance works have been re-sited to safe areas.
• The Provider has been informed that at the time of inspection - the support inspector requested and was shown the risk assessment regarding use of candles and did not advise that the assessment was inadequate. The Provider has viewed and is assured that risk assessments are in place and dictate that candles are only used in the presence of staff during religious or mediation activities. Risk Assessments indicate that non-battery-operated Candles are only permitted in communal areas when staff are present.
• Having requested a further inspection of all doors by an external fire consultant following the inspector's conflicting judgement, the Provider is assured that following minor adjustment to three doors – all doors throughout the nursing home meet regulatory compliance in terms of 'gaps'. Professional fire gap gauge tools have been purchased for utilisation to routinely check all doors and implement remedial measures if required.
• Heat detectors have been replaced with smoke detectors in 3 x areas as required.
• All individual PEEPS have been reviewed and updated to include correction of a typo error indicating the number of staff required for evacuation and resulted in the re-education of staff regarding importance of recording accurate information.
• Additional fire drills and enhanced fire training by external experts have taken place to include evacuation of larger number of residents with night and day staff numbers, and further training is scheduled.
• Available information to the Provider shows that the centre has 2 main fire compartments and a number of identified 'safe horizontal zones.' Information available to the Provider indicates that the 'safe horizontal zones' are considered to be effective for fire containment, have regulatory compliant fire safety doors and fire rated ceilings, and that compartment boundary structures consist of floor to roof level fire walls.
• An external Fire Safety company has consulted with architects and the Provider. Having received revised building plans - the Fire Safety Consultant is currently preparing new fire evacuation maps and escape routes which will clearly identify all evacuation routes – drafts of which are currently displayed prominently in the centre. An additional comprehensive assessment by this Fire Safety Consultant has been scheduled to take place in February 2025.
• On-site staff accommodation utilised by eleven members of staff ensures the night-time availability of an additional seven staff in the event of a fire to ensure resources for a safe evacuation. Additional off-site staff accommodation in proximity to the nursing home is utilised by a further six staff members and further ensures availability of staffing resources for evacuation.
• Instructions in the event of fire are displayed throughout the centre, some were, with other wall furnishings, removed temporarily during the duration of painting of the premises, which was taking place during the inspection process, and on completion of painting works these signs were re-displayed.
• Alterations have been made to the side entrance gate to ensure it is easily opened if required as an exit route.
• The Provider has been assured by Electrical contractors and inspection that LED lighting/ fittings in the centre are surface mounted and do not affect the effectiveness of the fire-rated ceilings.
• 2 x 60-minute FSDS doors i.e. fire and smoke doors have been manufactured and

installed by a qualified fire safety contractor.
• A Fire Stopping report by external fire consultants has been carried out and Fire stopping works are scheduled.
• The Provider can confirm that the correct annotation of detector activation and location is linked to the Fire Panel.
• Following receipt of the inspection report and required clarification of alarm system, the Provider notes that the quarterly Fire Panel inspection reports are always available in a Fire Box with the Fire Register beside the fire panel and clearly indicates the nursing home has an L1 system. This is further evidenced by a letter of confirmation from the installer.
• Planned repairs and replacement of closures/fittings on external fire exit doors has been completed.
• Quarterly reports for the fire alarm system are permanently stored in the Fire Box beside the fire panel and always available for inspection.
• A letter from our Electrical Contractor to the Provider was submitted to the inspectorate confirming the status of electrical (PAT) testing as being completed. PAT Testing due/scheduled for November 2024 has been completed and Certificate submitted. Our electrical contractor advised that FWT is included in the periodic inspection report as available.
• Confirmation has been received from Fire Safety experts in relation to fire door report queries.
• An additional Fire Safety Assessment by external Consultants is arranged for 24/02/2024 and pending receipt of their final report, the provider will be guided by the content and take actions considered necessary.
• A nighttime inspection of emergency lighting, generator provided lighting, and external road lighting clearly indicates sufficient illumination of escape routes.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

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:
Having reviewed all Care Plans, the provider is assured that all plans and assessments are comprehensive and updated. Frequency of Care Plan review by the Provider and Governance committee has been increased to ensure regulatory time-frame compliance, and additional training provided to nursing staff.

Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: HSE external Occupational Therapy staff were consulted and requested to ensure written guidance was available in addition to verbal training and recommendations provided for staff regarding the use of individual seating and safety equipment provided by the HSE. Retrospective written guidance is now available and attached to electronic records. Provision of manufacturer equipment manual is also required to be provided by OT for new/recommended individual seating.	

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 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	14/10/2024
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	28/05/2025
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	Substantially Compliant	Yellow	16/10/2024

	implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	17/11/2024
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.	Substantially Compliant	Yellow	17/11/2024
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	
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	Substantially Compliant	Yellow	31/10/2024

	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.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	
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	Not Compliant	Orange	

	and safe placement of residents.			
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.	Not Compliant	Orange	
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	16/10/2024
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	16/10/2024
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the	Substantially Compliant	Yellow	16/10/2024

	care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.			