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:	Aperee Living Ballygunner
Name of provider:	Aperee Living Ballygunner Limited
Address of centre:	Bishopscourt, Ballygunner, Waterford
Type of inspection:	Unannounced
Date of inspection:	11 November 2022
Centre ID:	OSV-0000236
Fieldwork ID:	MON-0038391

About the designated centre

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

Aperee Living Ballygunner was purpose built as a designated centre in 2006. It provides continuing, convalescent, palliative, dementia and respite care for up to 64 residents. It is situated on the outskirts of Waterford City and is in close proximity to all local amenities. It is a mixed gender facility and caters for residents of all dependency needs from low to maximum, predominately to people over the age of 65 but also caters for younger people over the age of 18. The centre comprise of two floors, with two elevators servicing each floor. Resident's accommodation is provided in 54 large single bedrooms, in one large four bedded room and in three twin bedrooms all which are en-suite. A number of bedrooms also have their own sitting room area provided in a suite type accommodation. There is a large central dining room, a sunroom, an oratory and a number of sitting rooms for residents use. Plenty of outdoor space is available including an internal courtyard with raised flowerbeds and seating areas. Nursing care is provided 24 hours a day, seven days a week supported by General Practitioner (GP) services.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	61

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
Friday 11 November 2022	11:00hrs to 18:50hrs	Niall Whelton	Lead

What residents told us and what inspectors observed

This was an unannounced one day risk inspection to monitor compliance with the regulations made under the Health Act 2007 (as amended). The inspector was met by the person in charge, who facilitated the inspection. This inspection included a focused review of fire precautions.

Following an introductory meeting, the person in charge accompanied the inspector on a walk-through of the centre.

Aperee Living Ballygunner is within a three storey building, with the designated centre occupying all of the ground floor and portions of the lower ground floor and first floor. The building was on a sloping site; the main entrance was at ground floor with final exits available from both ground floor and lower ground floor.

Escape routes were noted to be clear and unobstructed. The inspector noted when the adjacent school finishing time came around, the carpark was being used for parking for a short period of time. During this time, the pathway to the side was obstructed and would hinder escape out of the building. There was no signage to prevent this practice.

During the walkthrough of the centre, deficits to fire doors were evident. The inspector noted gaps to doors throughout and some were missing the appropriate heat and smoke seals.

The inspector was advised that all beds were fitted with a ski sheet to assist evacuation. Of the beds looked at by the inspector, they were found to be in place and fitted.

Two hourly checks were being completed by a night porter and the inspector saw tags throughout the building which were used to track the night time checks by the porter.

The inspector saw progress was made with the replacment of carpets. The linoleum flooring within corridors was torn in a number of places. The laminate covering to cupboard doors within the first floor nurse station was loose and falling off; this would be difficult to clean. The sluice room had been fitted with appropriate racking for bed pans and the sluice machine in each sluice room was working and serviced up to date. The walls in a laundry store were damaged from a former leak and the wall to the sluice/laundry store lobby was damaged.

The next two sections of this report present 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

Aperee Living Ballygunner Limited was the registered provider for this designated centre. The clinical management of the centre was led by the person in charge (PIC) who was supported by an assistant director of nursing (ADON), clinical nurse managers (CNM's), nursing staff, health care assistants, kitchen staff, housekeeping and laundry staff, adminstration and maintenance staff.

While the inspector found that the day-to-day governance systems within the centre were adequate, the organisational structures in place to support the centre were weak. The registered provider of this centre is Aperee living Ballygunner Ltd. Recent changes in this company's structure had resulted in a reduced organisational support team. The impact of these changes was evident in the lack of progress made in relation to action that had been required to address significant fire safety issues. These had been identified in a fire safety risk assessment conducted by the provider in January 2022. This assessment had identified five extreme risks and ten high risks (requiring urgent action within three months).

There was little meaningful progress made on the identified extreme risks. A red risk relating to inappropriate storage in electrical and plant rooms had been addressed locally by the staff in the centre. The remaining outstanding red risks were dependent on the registered provider to address. At the time of the inspection there was no time bound plan available to address the extreme risks. As a mitigating measure, an additional night porter was on duty; responsibilities included two hourly walk-thoroughs of the centre. Both night porters had attended fire safety training in the centre with other staff.

The routine checks by the night porter were not identifying fire safety deficits identified on this inspection. For example, doors to the sluice room and linen store were not provided with all the features of a fire door.

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

Regulation 23: Governance and management

In consideration of the findings of the fire safety risk assessment of November 2021 and the findings of this inspection in relation to Regulation 28, the inspector found that the provider had failed to ensure that the management systems in place ensured the safety of residents in the centre. The was evidences by;

- failure to date to address, and failure to have a time bound plan of action for, the fire safety risks identified in the aforementioned fire safety risk assessment

- failure to ensure the adequate arrangements were in place to maintain the means of escape and fabric of the building

Judgment: Not compliant

Quality and safety

While effective management at a local level within the centre contributed to managing the risk of fire, they did not fully mitigate the risk of fire to residents living in the centre. The deficits to the compartment walls, general fire sealing of gaps and holes in fire rated construction, inadequate fire doors, the upgrade of the fire alarm system to ensure adequate coverage were all outstanding.

There was a comprehensive Emergency plan in place which was issued in September 2021. This had not been updated to reflect the identified risks of fire safety in line the centres own fire safety policy.

Within the centre, the inspector noted some quality improvement strategies recently implemented. For example, when the fire alarm is tested, this is used as an opportunity to provide additional learning to staff. The records for these sessions included random fire safety topics each week to underpin staff knowledge. Staff were also selected each week to assist with the fire alarm test to give staff an opportunity to familiarise themselves with the operation of the fire alarm panel.

Fire compartments were identified with signage on the wall to alert staff to the compartment they were in.

The inspector reviewed fire drill records and these were found to be comprehensive and included learning and areas for improvement.

The inspector noted within the risk register that two residents had specific requirements to have the small leaf of their bedroom door open to facilitate independent movement through the door. This was risk assessed and known by the staff spoken with, who indicated that those doors would need to be closed in the event of a fire. However, one residents bedroom was found to have the automatic closing device disconnected and this was not risk assessed. The person in charge confirmed that they are looking at more appropriate solutions to facilitate the door being left open.

Notwithstanding the aforementioned good practice, the registered provider was not compliant with regulation 28; details of this are set out under regulation 28 of this report.

The inspector followed up on the actions for Regulation 17 Premises, from the previous inspection in July of this year. Some actions were outstanding but the due date for completion of these actions had not yet passed. The person in charge

confirmed that these actions would be complete on time. Further issues with the premises were identified on this inspection and there are detailed under regulation 17.

Regulation 17: Premises

While the date for completion of actions from the previous inspection had not yet passed and there was plans in place to address those actions, further issues with the premises were noted on this inspection which required action to ensure compliance with Regulation 17 and Schedule 6:

- the linoleum flooring in some corridors was torn
- the laminate covering to cupboard doors in the nurse station were loose and would not allow effective cleaning
- the wall in the corner of the large dayroom/dining room, was missing a section of the skirting boards
- in the large dayroom/dining room, there was activities equipment stored in boxes on the ground
- there was water damage to a wall in a laundry store from a former leak
- the wall to the lobby to the laundry store and sluice room was damaged
- the inspector observed some ceiling times had been cut to allow down stands for the provision of magnetic devices for fire doors, however in some cases the ceiling tile was damaged
- the assisted bathroom was now being used for hoist storage and a small first floor dining room as a physiotherapy room; these was not reflected on the registered floor plans

Judgment: Not compliant

Regulation 28: Fire precautions

At the time of inspection, the registered provider was not taking adequate precautions to ensure that residents were protected from the risk of fire, nor were fire precautions being adequately reviewed. For example;

- four red risks, identified in the fire safety risk assessment in January 2022, had not been actioned
- the centres emergency plan had not been updated in line with the centres own fire policy to reflect the identified fire risks
- the arrangements for the storage of oxygen cylinders was not in accordance with the centres own oxygen policy. Excessive cylinders were stored in the room behind the nurse station
- the inadequate containment to service shafts meant that fire could spread

vertically
- hoist batteries units were observed to be loose on the ground and were not appropriately mounted to the wall

The arrangements for providing adequate means of escape including emergency lighting were note effective:

- escape routes were not adequately protected from fire risk rooms due to deficient fire doors
- the external escape route to the rear consisted of a gravel pathway and would not be suitable for evacuation aids or for residents who experienced mobility impairments
- adequate emergency lighting was not provided along all external escape routes
- an exit door to the rear was fitted with a chain to prevent the door being caught by the wind, however the chain restricted the door from opening fully
- the directional arrow to an exit sign at first floor was not in the direction of the stairs exit

The arrangements for maintaining fire equipment were not effective:

- fire doors were not being maintained in good working order. Examples of deficiencies included: excessive gaps where double leaf doors met, broken hinges, screws missing to hinges and automatic closers not effective to fully close the door
- the service records for the emergency lighting were not in line with an appropriate standard

The measures in place to contain fire were not effective. Three of the red risks identified in the fire safety risk assessment related to fire containment, none of which were actioned;

- identified deficits to fire doors throughout had not been addressed. Fire doors were not effective to adequately contain fire
- identified breaches in fire compartment boundaries were outstanding
- identified containment deficits to service shafts were outstanding
- the doors to the sluice and linen store at first floor were not fitted with heat and smoke seals or automatic closing devices

The arrangements for detecting fire were not adequate, for example:

- some of the service shafts on bedroom corridors were not fitted with smoke detection
- the hoist store was not fitted with a smoke detector

The arrangements for evacuating residents required improvement:

- the assessed needs of residents was assessed through a personal emergency evacuation plan. These were in the process of being incrementally updated resulting in different information being included. They were not all

consistently in the same format

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

- the floor plans displayed included a 'you are here' and escape routes. They were difficult to read and did not include any procedures to follow
- the floor plans adjacent to the fire alarm panel were small and it was not clear what information was contained within them as they were difficult to read
- procedures were displayed for visitors, however not for staff

Judgment: Not 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
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Not compliant

Compliance Plan for Aperee Living Ballygunner OSV-0000236

Inspection ID: MON-0038391

Date of inspection: 11/11/2022

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: Where fire safety precautions have been identified as being required in the Fire Safety Risk Assessment, but are not currently implemented, the Register will be updated to detail a timebound list of actions to mitigate against any risks identified and reduce all identified risks to an acceptable level. The Provider is currently engaging with a competent construction company to address these remedial works required with urgent effect. Adequate arrangements to maintain the means of escape and fabric of the building is detailed in Regulation 28: Fire Precautions. ***This compliance plan response from the registered provider did not adequately assure the chief inspector that the actions will result in compliance with the regulations.***	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: There is a programme of routine maintenance and refurbishing the physical environment of the facility, including fixtures, furnishings and fittings. Linoleum flooring replacement in corridors has been previously delivered under this programme and further flooring upgrades will be considered as part of capital projects request. A schedule of planned maintenance works has been implemented and will include:	

Replacement of laminate covering to cupboard doors in nurses station;
Replacement of skirting boards in areas required;
Repair of water damage to a wall in the laundry store;
Repair of damage to wall by the laundry store and sluice room
Repair of damaged ceiling tiles

All activities equipment have now been moved from the large day room/dining room and are stored appropriately in the centre.

Registered floor plans shall be updated to reflect the purpose of each specific room.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

Means of Escape –

• A door performance assessment shall be completed by a competent person to confirm door sets that may not provide the required fire performance. Subsequent to same, a repair/replacement programme shall be implemented.
• The Provider shall ensure the final exit on an escape route to the outside shall lead to an area of safety. An appropriate pathway shall be installed, with removal of gravel surfaces.
• Emergency lighting shall be reviewed and provided outside the building and beside final exits.
• The residential home shall ensure that doors on escape routes are not fitted with restricted devices preventing the door from opening fully. Chain device located on 1 exit door has been adjusted, enabling the door to be opened fully.
• The directional arrow to an exit sign on the first floor will be corrected to face in the direction of the stairs exit.

Maintaining Fire Equipment:

• A door performance assessment shall be completed by a competent person to confirm door sets that may not provide the required fire performance. Subsequent to same, a repair/replacement programme shall be implemented.
• Emergency lighting is installed in the Designated Centre. The home shall ensure records are maintained to Irish Standard I.S. 3217:2013+A1:2017.

Fire Containment:

• A door performance assessment shall be completed by a competent person to confirm

door sets that may not provide the required fire performance. Subsequent to same, a repair/replacement programme shall be implemented.
• Remedial works to commence shall include upgrades to fire compartment boundaries and deficits in service shafts.
• Heat/smoke seals and an automatic closer shall be fitted to the door of the sluice and linen store on the first floor.

Fire Detection:

• Smoke detectors shall be installed in the hoist store room and some service shafts where detectors are not fitted.

Evacuating Residents:

• Subsequent to Inspection carried out November 11th, a full review of PEEPs for the home was completed and updated to a standardized format and reflecting current resident assessed needs. PEEPs shall be reviewed regularly in line with the review of the assessed needs of residents or more frequently as care and support needs change.

Procedures to follow in the event of Fire:

• A review of all floor plans in the building shall be conducted and updated where required to an legible format and include details of procedures to follow in the event of a fire.
• Notices for staff on "What to do in the case of a fire" will be completed. Fire procedures notices shall be displayed in a legible format in a prominent location.

This compliance plan response from the registered provider did not adequately assure the chief inspector that the actions will result in compliance with the regulations.

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 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	31/07/2023
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	01/01/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service	Not Compliant	Orange	01/01/2023

	provided is safe, appropriate, consistent and effectively monitored.			
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	03/01/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	03/01/2024
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.	Not Compliant	Orange	03/01/2024
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	28/02/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	03/01/2024
Regulation 28(2)(iv)	The registered provider shall	Substantially Compliant	Yellow	18/11/2022

	make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre 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	31/03/2023