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:	AbbeyBreaffy Nursing Home
Name of provider:	Knegare Nursing Home Holdings Ltd
Address of centre:	Dublin Road (N5), Castlebar, Mayo
Type of inspection:	Unannounced
Date of inspection:	22 August 2024
Centre ID:	OSV-0000308
Fieldwork ID:	MON-0042998

About the designated centre

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

AbbeyBreaffy Nursing Home is a purpose-built facility that provides care for 55 male and female residents who require long-term care or who require short periods of care due to respite, convalescence, dementia or palliative care needs. Care is provided for people with a range of needs: low, medium, high and maximum dependency.

The centre is located in a countryside setting a short drive from the town of Castlebar just off the N5. The atmosphere created is comfortable and there is plenty of natural light in communal areas and in bedrooms. Bedroom accommodation consists of four double rooms and 47 single rooms of which 50 have ensuite facilities. There are toilets including wheelchair accessible toilets located at intervals around the centre and close to communal rooms. There are several sitting areas where residents can spend time during the day. There were dementia friendly features in place to support residents' orientation and memory and this included signage and items of memorabilia that included displays of china and old style equipment. An accessible and safe courtyard garden is centrally located and has been well cultivated to provide interest for residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	52

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 22 August 2024	09:00hrs to 18:00hrs	Michael Dunne	Lead
Thursday 22 August 2024	09:00hrs to 18:00hrs	Gordon Ellis	Support

What residents told us and what inspectors observed

On the day of inspection, the inspectors observed that residents were supported to enjoy a good quality of life supported by a team of staff who were kind, caring and responsive to their needs. The overall feedback from residents was that they were happy living in the centre and with the quality of care they received. One resident told the inspectors that "they were glad that they came to live in designated centre and that staff do all they can for you". Notwithstanding the positive feedback the inspectors found that there were actions required to ensure the service provided met the assessed needs of the residents. These areas are discussed in more detail under the relevant regulations in this report.

Upon arrival the inspectors completed the sign in process and proceeded to meet with the person in charge to discuss the format of the inspection. Following the introductory meeting with the person in charge, the inspectors commenced a tour of the designated centre where they had the opportunity to meet residents and staff as they began preparation's for the day. There were 52 residents living in the centre on the day of the inspection.

AbbeyBreaffy Nursing Home provides long-term care and respite care for both male and female adults with a range of dependencies and is located close to the town of Castlebar in County Mayo. Accommodation is provided mainly in single room accommodation with a number of these rooms serviced by an ensuite facility which includes a wash hand basin, toilet, and shower area. There are also four twin rooms available in this centre. The layout of one twin room bedroom 55 was not suitable for two residents sharing and, these findings are discussed under Regulation 17. At the time of this inspection bedroom 55 was being used for single occupancy with one resident residing in the room.

During the walkabout the inspectors observed that the programme of refurbishment and redecoration had not been been completed in line with the time lines set out in the providers compliance plan from the previous inspection. The programme for painting of residents' bedrooms and communal areas was ongoing at the time of this inspection. Those areas of the centre that had undergone redecoration looked bright and fresh and improved the lived environment for the residents. The inspectors noted that the provider had completed a number other improvements which included the installation of new flooring and hand hygiene sinks in key locations throughout the centre. Overall, the centre looked bright, clean and welcoming. Long corridors were adorned with pictures and murals to provide points of interest and to help residents to orientate themselves when mobilising around the designated centre.

Observations confirmed staff interactions with residents were caring, gentle, and respectful. It was clear from observations throughout the day that staff were aware of residents assessed care needs and were able to respond to those needs in a person centred manner. In instances where residents required personal care

support, this was found to be provided in a discreet manner with due respect for residents needs and choices.

Some residents who presented with responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment), were supported in a well managed and constructive manner. These interventions de-escalated potentially risk situations while at the same time respecting the residents autonomy and safety.

Although staff were attentive to residents needs, the inspectors observed a period before lunch where eight residents were sitting in the main foyer area and there were no staff available in the area to provide support and supervision for these residents. The person in charge confirmed that a staff member was assigned to monitor this area however the inspector observed that the member of staff was busy attending to other residents needs.

The inspector observed activities provided for residents on the day. Activities included an exercise game (ball toss), a music session and a knitting club activity which residents appeared to enjoy. Residents who attended these activities were supported and encouraged to participate by the staff team present. Residents told the inspector about the barbeque that had been held the day before the inspection and commented on how nice the food was. The provider maintained a newsletter which provided residents with information about key events in the centre and about planned trips out to areas of interest. The next trip was arranged to visit a local lake.

Residents had unrestricted access to all areas of their home including access to outside facilities.The communal garden area was well-maintained and was well-appointed with flowers and shrubs and garden furniture. There was adequate seating to cater for the number of residents using this facility.

Several residents were observed to be using comfort chairs and required staff to assist them to access communal areas of the home and their own bedrooms and toilet facilities. Inspectors noted that staff carried out resident transfers in a co-ordinated manner while providing encouragement and support to the residents during this activity.

Residents were complimentary about the food served in the centre, and confirmed that they were always offered a choice of menu options. Residents were seen to be assisted discreetly with their food and drinks where required. The inspectors attended a meal service and observed there were adequate numbers of staff available to support residents during mealtimes. There were a range of snacks and drinks made available to residents outside of regular mealtimes. On the day of the inspection residents had a choice of main meal which consisted of a pork steak or roast chicken. There were a range of desserts to choose from including strawberry gateaux and ice cream.

The inspectors met and spoke with visitors who attended the centre and they confirmed that their loved ones were well-cared for. In addition, visitors added that

the staff team kept them informed about changes in residents health conditions and about health care appointments.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

For the most part there were management systems in place which provided oversight to maintain standards of care for the residents. The management team were proactive in response to issues identified through audits with a focus on continual improvement however not all improvement action plans were found to be effective in addressing areas that required improvement. Furthermore, more focus and effort were now required to ensure that resources were made available to address repeated non compliant findings under Regulations 17 and 28. These issues are described in more detail under the relevant regulations.

This was an unannounced risk inspection to monitor the registered provider'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 actions the provider had agreed to implement as a result of the findings of an inspection carried out in September 2023.

The inspectors also followed up on unsolicited information received by the Chief Inspector in 2023 and 2024. This information related to the quality of care and support provided in the designated centre. Records relating to the clinical support for residents were reviewed during the inspection and the inspectors found that there was insufficient evidence to substantiate these concerns.

While the inspectors found that the registered provider had made a number of improvements across areas of the service, there were also a number of recurring non-compliance's where actions had not been carried out to bring the centre into compliance with the regulations. The failure to commit to a robust time bound plan to upgrade the premises, and improve fire safety measures in the centre meant that known risks had not been effectively mitigated against. The inspectors requested an urgent compliance plan following this inspection due to concerns in relation to Regulation 28: Fire precautions.

The designated centre is operated by Knegare Nursing Home Holdings limited and is the registered provider for AbbeyBreaffy Nursing Home. There is a clearly defined management structure in place that identified roles and responsibilities within the designated centre. The person in charge is supported by an assistant director of nursing (Adon) a clinical nurse managers (CNM), staff nurses, health care assistants, activity staff, household, and maintenance personnel. In addition, the oversight of the service had been strengthened through the appointment of a director of

operations, a regional manager and a clinical services manager since the last inspection.

There were regular governance meetings held at both local and senior management level to review the quality of the service provided. The provider had completed a comprehensive report on the quality and safety of care for 2023 which also included an improvement plan for 2024. This report provided key information about the performance of the designated centre and the involvement of residents in the planning of the service going forward.

There was a well-established audit schedule in place to monitor the standards of care provided. Results of audits reported high levels of compliance. Although, there was ongoing monitoring of care provision, the inspectors was not assured that information collected was being used to drive continual improvement, for example some action plans were repetitive in nature and did not effectively identify and address the underlying causes of the poor performance.

The provider ensured that all staff roles had been filled and at the time of this inspection there were no vacancies on the roster. Records reviewed confirmed that 12 staff had been recruited since the beginning of the year. However a review of staff information against the provider's statement of purpose found discrepancies in the numbers of staff identified as whole time equivalents (the number of staff who would be employed if all staff were employed on a full-time basis). In some cases staff were identified as a full (WTE) while they were working part-time and in other cases the actual numbers of staff were incorrect.The person in charge updated the staffing information in the statement of purpose on the day of the inspection.

Inspectors were not assured that there were sufficient numbers of staff available in the centre taking into account the assessed needs of the current residents. At the time of this inspection there were 11 residents who were assessed as maximum dependency and who would normally require the assistance of two staff with their care support. The inspectors observed that not all residents were in receipt of ongoing supervision as the foyer area where eight residents were sitting was left unsupervised for 15 minutes while staff were busy elsewhere. In addition, inspectors were not assured that the provider had allocated sufficient numbers of staff during the night to carryout a fire evacuation in a timely manner bearing in mind the dependency levels of the residents and the size of the compartments to be evacuated. This finding is discussed in more detail under Regulation 28.

There was a comprehensive training programme in place which incorporated a selection of both face to face and online training. Records confirmed that all staff were up to date with their mandatory training in safeguarding, fire safety and manual handling. Supplementary training included modules on infection prevention and control, training in medication management, wound management, dysphagia and cardio- pulmonary resuscitation (CPR). The provider confirmed that training in complaints management had been arranged. Discussions with staff confirmed that they attended training on a regular basis and that the knowledge gained gave them a better understanding of their roles and on how to ensure residents received person centred care. Staff who attended fire training confirmed that they were

knowledgeable of the fire procedures in place however they were unable to identify the fire compartments in the designated centre which were used for horizontal evacuation in the event of a fire emergency.

Incidents occurring in the centre were being recorded electronically and there was good oversight and monitoring of incidents by the person in charge. All incidents had been reported to the Chief Inspector, as per regulatory requirements. Inspectors found that the provider had improved the security of records in accordance with the regulations. The inspectors found that the store room for the maintenance of records was locked.

The required changes to the complaints policy identified at the last inspection had not been fully completed and meant that there was a risk that complainants may not be fully communicated with about how requests for reviews were processed, the person in charge made the required amendment to the policy on the day of the inspection.

A review of complaints records found that complaints were investigated in accordance with procedures set out in the designated centre's complaints policy. Records were well-maintained and there was oversight and evaluation of complaints in the centre in order to drive service improvement. At the time of this inspection there was one open complaint which was being processed, while four other complaints received since the last inspection had been closed out with the satisfaction of the complainant recorded.

Regulation 16: Training and staff development

Staff had access to appropriate training. Records showed that staff were up to date with their mandatory training requirements. New staff were completing induction training which included fire safety, transmission based precautions and safeguarding training.

Judgment: Compliant

Regulation 21: Records

The inspectors found that records were maintained in line with the requirements of the regulations. Records were found to be stored securely and were made available for the inspectors to review. The inspectors noted that in instances where residents information was shared with other relevant parties that there were arrangements in place for gaining residents consent to do this.

Judgment: Compliant

Regulation 23: Governance and management

The provider had failed to ensure that the resources required to address the known fire safety risks in the designated centre were addressed in a timely manner. As a result a number of red and amber fire safety risks had not been addressed following the previous inspection in September 2023 and the provider's own Fire Safety Risk Assessment (FSRA) dated May 2023. This included a review of staffing levels to ensure the staffing resource was adequate at all times taking into account the known risks in the centre.

The provider had failed to provide the resources to complete the planned upgrade of the premises in line with the compliance plan submitted following the September 2023 inspection. The provider failed to implement actions identified in previous inspections held in June 2022 and January 2023 and September 2023, to reconfigure bedroom 55 to ensure that the layout of this twin bedroom would meet the needs of two residents sharing the bedroom and would be compliant with Regulations 17 and 9.

The inspectors found that the registered provider had management systems in place to monitor the quality of the service provided however some actions were required to ensure that these systems were sufficient to ensure the services provided are safe, appropriate and consistent. For example:

- The overall management and planning of centre upgrades was not effective. Dates for works to be completed in relation to the premises and fire safety, submitted by the provider in several compliance plans were not met and were extended on a continual basis.
- The oversight of evacuation drills was not sufficiently robust to provide the necessary assurances that all residents could be evacuated in the event of a fire emergency.
- The day to day management of fire risk in the centre did not ensure that risks were identified and managed effectively. As a result two urgent compliance plans in regard to fire risks were issued to the provider in regards to lack of compartmentation, evacuation procedures, staffing resources, evacuation policies and staff awareness in light of the current significant fire risks in the centre, and to review the programme of fire safety works to ensure the safety of the residents.

Judgment: Not compliant

Regulation 3: Statement of purpose

There was a statement of purpose which required minor changes to ensure it reflects the information required in the regulations. For example:

- The whole time equivalent records for reception, administration and care assistants staff and the number of staff covering these roles required updating as they were incorrect on the statement of purpose dated 20 August 2024.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was an accessible complaints policy and procedure which was displayed in a prominent position in the designated centre. This policy required updating to ensure,

That complainants were provided with a written response following an outcome of a review.

Judgment: Substantially compliant

Regulation 15: Staffing

A review of the centres rosters confirmed that staffing numbers were consistent with staff numbers identified in the centre's statement of purpose. However, inspectors found,

- There was a period of 15 minutes where eight residents were left without support and supervision in the foyer area.
- There were insufficient numbers of staff available at night time to ensure residents could be evacuated to a place of safety in a timely manner in the event of a fire emergency in the designated centre.

Judgment: Substantially compliant

Quality and safety

Residents were supported and encouraged to have a good quality of life which was respectful of their choices. There was evidence that residents were in receipt of positive health and social care outcomes and that their assessed needs were being met by the registered provider. Regular consultation between the provider and residents ensured that resident's voices were being heard in this centre. However while there had been some improvements in compliance in respect of Regulation 28: Fire safety, the provider failed to complete fire safety works in line with the time lines they submitted as part of the compliance plan for the inspection carried out in September 2023.

The provider was found to have improved compliance with the regulations in respect of infection prevention and control through the installation of hand hygiene sinks and the introduction of a more robust system for the cleaning of residents transfer equipment in between resident use.

Notwithstanding these improvements, the time lines for the the upgrade of the premises submitted by the provider in previous compliance plans had not been met. In addition to the findings from the previous inspection in September 2023, the inspectors found additional non compliance with Regulation 28 which necessitated two urgent action plans being issued to the registered provider requiring them to take urgent actions to mitigate the risks in the time frames imposed by the Chief Inspector.

Following the inspection the provider submitted a response as requested to the urgent action plans. However, these responses did not provide the required assurances and the provider was required to review and improve their response setting out the actions they intended to take to ensure that there were adequate fire precautions in place in the designated centre.

The majority of resident bedrooms had been repainted and this improved the ambiance of these rooms. Residents were seen to personalise their own lived environment with items individual to them. Rooms were clean and well-maintained and there was sufficient space for residents to store their clothes and personal items. Some rooms also had their flooring replaced. As discussed elsewhere in the report the decoration of communal areas was ongoing.

There are a number of communal rooms available for residents to use. These rooms were found to be tastefully decorated and suitable for their intended purpose. Residents had unrestricted access to a large garden area which was secure and contained sufficient seating for residents to use when visiting this area.

Residents could retain the services of their own general practitioner (GP) but also has access to a local GPs who visited the centre on a regular basis. There were arrangements in place for out of hours medical support. Care records confirmed appropriate referral to and review by health and social care professionals where required, for example, dietitian, speech and language therapist and chiropodist. Residents had access to specialist services such as psychiatry of old age and nurses had access to expertise in tissue viability when required. Clinical staff were able to avail a selection of training resources to maintain their professional competence.

Clinical interventions were subject to routine audit. The provider maintained regular clinical oversight of falls, wound care, nutrition and hydration, medicine management, antibiotic use and skin care. The provider also added additional audits for review in 2024 which included continence, responsive behaviours, use of restraint, care planning and activity support. A review of clinical, operational and environmental information was discussed during provider meetings and actions identified for improvement where necessary.

Residents' needs were comprehensively assessed using validated assessment tools at regular intervals and when changes were noted to a resident's condition. The inspector saw that residents appeared to be well cared for and residents gave positive feedback regarding their life and well-being in the centre. While there was oversight of the care planning process, the inspector found that care interventions for two residents with communication needs was not appropriate and lacked sufficient detail to direct effective care interventions to meet the assessed need.

The registered provider had ensured effective governance arrangements were in place to ensure the sustainable delivery of safe and effective infection prevention and control and antimicrobial stewardship in the centre. The installation of hand hygiene sinks, new flooring, improved storage and segregation of clinical and non-clinical items along with improved cleaning protocols meant that the provider improved compliance with the regulations.

Residents' rights were protected and promoted. Individuals' choices and preferences were seen to be respected. Residents were consulted with about their individual care needs and had access to independent advocacy if they wished. Visiting was facilitated in the centre in line with national guidance. There was a good programme of individualised and group activities available. Residents spoken with on the day told the inspector about the barbeque which was held the previous day and on how they enjoyed it. A review of activity records confirmed that trips out to local places of interest was a feature of the activity support. Some notable events included, trips to garden centres, local wollen mills and a local pet farm.

Regulation 11: Visits

Visits were seen to take place in line with visiting guidelines. Visitors were seen attending the centre throughout the inspection. Discussions with residents and visitors confirmed that they were satisfied with the arrangements that were in place.

Judgment: Compliant

Regulation 17: Premises

The provider failed to implement actions identified in previous inspections held in June 2022 and January 2023 and September 2023, to reconfigure bedroom 55 to ensure that the layout of this twin bedroom would ensure that each resident had sufficient personal space to accommodate a bedside locker and a comfortable chair beside their bed without encroaching on the other resident's bed space or blocking the other resident's access into and out of the room and their access to the en-suite facility.

The following areas identified on this inspection that required improvements in regards to Schedule 6 were as follows:

- The provider failed to implement actions identified in previous inspections held in June 2022 and January 2023 and September 2023, to reconfigure bedroom 55 to ensure that the layout of this twin bedroom would ensure that each resident had sufficient personal space to accommodate a bedside locker and a comfortable chair beside their bed without encroaching on the other resident's bedspace or blocking the other resident's access into and out of the room and their access to the ensuite facility.
- A number of ceilings had penetrations that required sealing.
- Some of the doors in the centre had signs of damage.
- In the hair salon, the inspectors noted a call bell was missing.

Judgment: Substantially compliant

Regulation 27: Infection control

The registered provider ensured that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority were implemented by staff. Up to date training had been provided to all staff in infection control, hand hygiene and in the donning and doffing of personal protective equipment (PPE).

- Regular audits of infection prevention and control, environment and hand hygiene found good levels of compliance the inspector also noted that staff were seen to perform hand hygiene tasks throughout the day.
- Effective cleaning processes were in place to support and maintain high levels of cleanliness.
- There were improvements found regarding the cleaning of equipment used for resident transfer. The provider had introduced a tagging system which confirmed when resident equipment was last cleaned.
- The storage and segregation of clinical and non clinical items in the main store room had improved.
- There was good oversight of antimicrobial stewardship in the designated centre.

Judgment: Compliant

Regulation 28: Fire precautions

Significant risks and associated non-compliance with the regulations as outlined below were identified to the provider during the inspection. These required urgent attention to safeguard the safety and well-being of service users. Following the inspection, the provider was issued with two urgent action plans.

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.

- A build-up of lint was found in a dryer in the laundry room. This created a potential fire risk as dryer lint is flammable.
- Residents were observed using a courtyard as a smoking area. However, this area was not provided with a call bell, a fire extinguisher or a suitable metal ashtray as residents were using the nearby plant pot.
- The inspectors noted deep fat fryers were located in a kitchen. A fire suppression system was not observed to be present. As such, this required a review by the providers' competent person.
- The inspectors noted a green break glass unit manual override device at one final fire exit door was found to be located at a height that may be difficult for some staff to access creating a risk that staff would not be able to override the door in an emergency.

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

The inspectors observed a designated escape route for residents and staff to use in the event of an emergency was through a smoking room from a day room. The inspectors were not assured this was a suitable means of escape and as such this required a review by the provider's competent fire person.

Furthermore, along another escape route, timber panelling was observed to be fitted to a ceiling. The inspectors were not assured the timber panelling would meet the required fire rating and could potentially compromise the means of escape in the event of a fire.

In addition to this, there was a significant lack of directional emergency signage throughout the designated centre to clearly indicate and direct service users to the

nearest fire exit in the event of a fire. This would cause confusion and delay in the event of a fire. .

Externally, while there was emergency lighting above most fire exits, there was not sufficient emergency lighting at the front, rear or sides of the building in order to illuminate all paths to the fire assembly point. In addition to this, some external paths were gravel based, uneven and would not be suitable to evacuate residents with medium to high dependencies who may require walking aids or wheelchairs to evacuate in the event of a fire.

Prior to this inspection, the provider had committed to address the fire risk in respect of the external paths by June 2024. This risk had previously been identified in the providers' fire safety risk assessment. However, this had not been resolved at the time of this inspection.

The provider did not provide adequate arrangements for maintaining the means of escape, building fabric and the building services. For example:-

In the dining room, a table and chairs were located in front of a designated fire exit. This impeded access to the fire exit and could delay egress in the event of a fire. Furthermore, a full length blind was present over a fire exit door. Prior to this inspection, the provider had committed to address the fire risk in respect of the blind by May 2024. This risk had previously been identified in the providers' fire safety risk assessment. However, this had not been resolved at the time of this inspection. These items were brought to the attention of staff who removed them on the day.

The inspectors noted several areas in the centre were noted to have utility pipes or ducting that penetrated through fire rated ceilings (walls and ceilings built in a way to provide a certain amount of fire resistance time), and these required appropriate fire sealing measures.

The quarterly maintenance certification records were available on the day of the inspection for the emergency lighting system and the fire detection alarm system. However, the annual maintenance certificate for the emergency lighting system was not available. Instead the inspectors reviewed the annual report that highlighted a number of faults and defects of emergency lighting were present on the system. There were no assurances that these faults had been addressed at the time of the inspection.

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

At the time of this inspection, the provider had not fulfilled previous commitments in regards to addressing fire risks in respect of; external evacuation routes and the removal of a blind over a fire exit. While the fire risks identified in the providers own Fire Safety Risk Assessment were scheduled to be completed in the coming months, the inspectors did not see progress in resolving these risks within the committed time frame.

The inspectors spoke with a number of staff. They acknowledged they were not informed of the current fire risks in the centre. Furthermore, fire evacuation policies and/or procedures had not been updated to reflect the known risks including the evacuation of the largest compartment which was found to accommodate up to 25 residents due to identified fire compartment deficiencies in this section of the building..

The inspectors did not have assurances that there was a comprehensive schedule of works in place to address all of the fire safety risks identified in the provider's own fire safety risk assessment completed in May 2023 in a timely manner. The provider had been required to submit the original fire safety risk assessment carried out by the providers competent fire consultant to the office of the Chief Inspector for review. However at the time of the inspection this original document had not been submitted.

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 were aware of the procedures to be followed in the case of fire.

While evacuation drills were taking place, the simulated evacuation drills reviewed were not based on a night time scenario when all 25 residents accommodated in the largest compartment in the building would be asleep in their rooms. Furthermore, drills did not accurately reflect all of the residents' evacuation requirements stated in their records. Following further correspondence with the provider after the inspection, the residents' personal emergency evacuation procedures were found to not be an accurate reflection of their evacuation needs and were subsequently updated by the provider.

In addition to this, staff spoken with were of the understanding that every cross corridor door was an indication of a fire compartment. However, this was not the case as the attic compartmentation boundaries did not align with the ground floor cross corridor fire doors. The integrity of compartment boundaries are paramount to ensure that when residents are moved to a place of temporary safety from a fire, they remain safe from the spread of smoke or fire before moving on to the next compartment. This has significant consequences for the evacuation design strategy of the centre if staff are not aware of these risks.

The registered provider did not have adequate arrangements for containment and for the detection of fire. For example:

The inspectors were not assured there were adequate compartmentation provided in the centre to facilitate progressive horizontal evacuation. The inspectors were informed on the day of the inspection that due to the deficiencies identified by the providers' fire consultant, there was a lack of compartmentation in the centre. This had resulted in a large compartment that accommodated up to 25 residents in one area.

In addition to this, fire doors were noted to have excessive gaps at the bottom/side/top and where double fire doors met. Smoke seals were absent

throughout the centre. Non-fire rated ironmongery were found throughout and the inspector was not assured a number of glazed vision panels would meet the required fire rating. Furthermore, some fire doors would not close fully when tested, were missing door closers and fire doors located in a laundry room did not meet the fire rating for a high risk room. Furthermore, a number of attic access hatches did not appear to be of the required fire rating.

The totality of the containment deficiencies present in the centre as outlined above have significant consequences for the containment of fire and smoke, the evacuation design strategy and ultimately for the care and welfare of residents living in the centre in the event of a fire in the centre.

A fully addressable L1 category fire detection alarm system was indicated on the fire alarm servicing records. However, the inspectors noted a fire detection was missing from a number of en-suites and a store room. This required a review by a competent person.

The provider had failed to provide adequate arrangement for evacuating all persons in the designated centre and the safe placement of residents in the event of a fire emergency. For example:

The inspectors were not assured based on the drills reviewed that staff are adequately prepared for the scenarios that were likely to be encountered by them in the event of a fire in the centre. Taking into consideration the level of residents' dependency levels, the size of a 25 bedded compartment and the current totality of the fire risks currently in the centre. These concerns were validated by the providers response to the urgent action plan where a simulated night time fire drill of the largest compartment accommodating 25 residents was over nine minutes to evacuate the residents. Following a review of the fire drill times the provider increased night time staffing levels by one staff each night.

Furthermore, the inspectors were not assured there were; adequate supervision of the remaining residents in the centre during an evacuation, to meet the fire brigade, to supervise residents in other areas of the centre and at the assembly area.

The displayed procedures to be followed in the event of a fire required a review by the provider. The fire evacuation plans required more detail. For example, there was no indication of the location of fire compartments, fire escape routes, fire extinguishers or call points.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The provider ensured that comprehensive assessments were completed to identify resident's care and support needs, however the transfer of information to relevant care plans did not clearly outline the required interventions to meet those needs.

For example,

- A communication care plan for a resident with a vision impairment did not give sufficient information to indicate how their assessed needs were going to be met.
- The interventions to support a resident where English is not their first language were non specific and as such would be ineffective in meeting the assessed needs of this resident.

Judgment: Substantially compliant

Regulation 6: Health care

The residents' nursing care and health care needs were met to a good standard. There was evidence that residents were referred to other health and social care professionals as required. There were arrangements in place for residents to access physiotherapy and chiropody.The designated centre received support from their local pharmacist regarding the oversight of medicines management. Tissue viability expertise was also available to support nursing staff with the management of wound care. A mobile X-ray service was now available for residents living in the designated centre which was well received by both residents and the management of the home.

Judgment: Compliant

Regulation 9: Residents' rights

The layout of twin bedroom 55 did not ensure that each resident's rights to privacy and dignity would be upheld. This room was occupied by one resident on the day of the inspection. All of the wardrobes storage facilities in the bedroom, were located in the bed space of the resident occupying bed 1. This meant that the resident in the second bed would need to enter the first resident's private space to access their wardrobe.

The layout of the room meant that when the resident in the first bed was accessing the en suite facility they would need to enter the second resident's bedspace.

The privacy curtain rail around the second bed did not provide enough room inside the curtain for this resident to carry out personal activities in private especially if they needed to use assistive equipment such as a hoist or comfort chair.

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 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 15: Staffing	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for AbbeyBreaffy Nursing Home OSV-0000308

Inspection ID: MON-0042998

Date of inspection: 22/08/2024

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:

• The provider has submitted a time-bound remedial works plan to the Regulator following the recent inspection, outlining measures to address all identified fire safety risks in the centre. To ensure resident safety during the interim period until these works are completed, a comprehensive mitigation plan has been implemented. This includes increasing nighttime staffing levels to enhance monitoring and response capacity, ensuring that any fire safety risks are managed effectively in the meantime.

• The provider confirms that Bedroom 55 will be reconfigured to meet the requirements for shared occupancy once it becomes vacant. The room has accommodated a single resident for over two years, ensuring respect for the resident's privacy and dignity in line with their preferences. The current single-occupancy arrangement are outlined in further detail under Regulation 9: Residents' Rights.

• Upgrades in the Center are progressing consistently, with resident-occupied areas prioritized by the provider. Upon completion of these areas, the service areas occupied by staff will undergo painting, with a target completion date of December 31, 2024.

• Re-education sessions, led by the Person in Charge and Assistant Director of Nursing began on August 27th, focusing on the center's updated evacuation policies and procedures, specifically tailored for the largest compartment. All available staff members have now completed this training. Staff members are now confident in their roles within the evacuation process.
To ensure preparedness, the PIC and ADoN have been conducting evacuation drills every two weeks, with six successful drills carried out since the last inspection. These regular drills serve to reinforce staff confidence and familiarity with evacuation procedures, compartmentation, and identified risks. The team will continue these fortnightly exercises to uphold a high standard of readiness and review evacuation times and staff

performance to ensure continuous improvement.

Additionally, the PIC and ADoN have conducted a comprehensive review of each resident's dependency level, updating Personal Emergency Evacuation Plans (PEEPs) to reflect current needs. This assessment, completed on August 23, 2024, will be subject to ongoing monitoring to ensure residents receive appropriate support during an evacuation. These combined efforts assure that the home remains well-prepared to safely evacuate all residents if necessary.

• The Provider is prioritizing fire safety improvements in the largest compartment as part of the ongoing fire safety enhancement program. The comprehensive schedule of fire safety works has been shared with the Regulator, with additional details outlined under Regulation 28, Fire Precautions.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

On the day of the Inspection, the Person in Charge updated the Whole Time Equivalent records on the Statement of Purpose for the reception, administration and care assistants staff to ensure it aligned with regulatory requirements.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

The complaints policy and procedure has been updated and is now fully compliant with regulations. The following changes were implemented:
• The policy now mandates that all complainants receive a written response outlining the outcome of the review, including any actions taken to resolve the issue and follow-up steps.
Completed 23/08/2024.

• Relevant staff have been trained on the updated procedure to ensure timely and effective written communication to complainants.
Completed 30/09/2024.

• Monthly audits will be conducted to ensure adherence to the updated policy and to confirm that written responses are consistently provided.
Completed 30/09/2024 and ongoing.

• Information for residents throughout the center has been updated to reflect the above.
Completed 23/08/2024.

Regulation 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

Immediately following the inspection, the Person in Charge reviewed and adjusted staff allocation to ensure a consistent presence in communal areas. Specific staff members are now assigned to monitor these areas during both day and night shifts, ensuring that assistance is readily available and residents are never left unsupervised. Action completed on 25/08/2024 and ongoing.
Additionally, staff break schedules have been reviewed and adjusted to eliminate any gaps in supervision during shift changes or breaks, allowing for effective coverage among staff members. Completed 25/08/2024 and ongoing.
An additional staff member has been added to the night shift to ensure sufficient personnel are available for evacuation, pending the installation of the fire doors and additional compartments. This action was completed on 14/10/2024.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

• Bedroom 55 has accommodated only one resident for over two years. The current resident has expressed a preference for the room to remain configured for single occupancy without additional furniture for a second resident. Consequently, any reconfiguration of this space will only be considered once it becomes vacant, preventing any disruption to the current resident, who is content with the existing arrangement

• Action has been scheduled to address fire penetrations on compartment lines, specifically where utility pipes or ducting penetrate to reinforce the center's fire resistance capabilities. The fire sealing work is set to commence on October 28th and is anticipated to be completed by November 8th.

• A comprehensive fire door audit has been completed, identifying a scope of work that

includes repairing any damaged doors, upgrading non-fire-rated ironmongery and glazed vision panels, as well as addressing any gaps and ensuring all doors close properly.

• A call bell system in the hairdresser unit has been installed. Completed 18/10/2024.

Regulation 28: Fire precautions	Not Compliant

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

• Lint removal in laundry room: A daily lint removal protocol has been implemented to ensure dryers are clear of lint buildup. Frequent checks have been scheduled by the PiC and ADoN to confirm compliance. Completed 23/08/2024 and ongoing.

• Call Bell and Fire Extinguisher Installation: The courtyard with a smoking area will be equipped with a call bell and fire extinguisher. Order has been placed and expected delivery by October 31st.
Floor-mounted and wall-mounted metal ashtrays were available for residents' use. Enhanced monitoring has been put in place to orient residents to use the metal ashtray instead of the flowerpot. Completed 23/08/2024 and ongoing.

• As per the Centre's Fire Safety Consultant, a comprehensive risk assessment has been conducted to identify and mitigate any fire risks associated with the use of deep fat fryers in the kitchen. Complete.

• The green break glass unit installed at the final exit has been verified to be within easy reach, as assessed with an individual of average height. Its current height placement is intended to reduce the risk of accidental activation. This unit serves as a back up release mechanism for the electromagnetic door lock, which is integrated with the fire detection system and will automatically release upon fire alarm activation. The access control release feature undergoes weekly testing, with any faults promptly reported.

Means of Escape:

• As per the Centre's Fire Safety Consultant advise, the exit via the smoking room is an alternative means of escape, in the event that the exit via the main foyer is not available this exit would be used. The smoking room is not an area of high fire load (nothing in the room), so would not be considered as a high fire risk. In reality the smoking room is used infrequently for short periods of time by residents who are supervised. The name 'smoking room' would lead to a natural concern but from a fire perspective however, the risks are very low.
• The timber panelling along the escape route ceiling has been treated with fire-rated paint, meeting necessary fire safety requirements. Completed 23/10/2024.

• Installation of additional directional emergency signage throughout the designated

center to clearly mark the nearest fire exits, has been scheduled with anticipated completion date November 15th.

• Enhanced emergency lighting has been installed around the building to ensure adequate illumination on all paths to the fire assembly point. A total of 17 twin-beam lights have been added at the front, rear, and sides of the building, completed as of 11/10/2024.

• Gravel-based footpaths have been replaced with concrete paths on September 29th, creating an even and stable surface suitable for residents with medium to high dependency levels, including those using walking aids or wheelchairs, to evacuate safely in case of an emergency.

• On the day of the inspection, the table and chairs obstructing the designated fire exit in the dining room were immediately relocated to ensure unrestricted access. Additionally, the full-length blind over the fire exit door, previously identified as a fire risk, was removed on-site to eliminate any potential delay in egress.

• Action has been scheduled to address fire penetrations on compartment lines, specifically where utility pipes or ducting penetrate to reinforce the center's fire resistance capabilities. The fire sealing work is set to commence on October 28th and is anticipated to be completed by November 8th.

A thorough review of the emergency lighting has been completed, including testing and replacing any units that did not meet standards. The Provider is also coordinating with the fire servicing company to address any "variations" noted in the Emergency Lighting Report, since these variations may be due to differences in standards based on newer building's that are not applicable to the Centre.

Fire Precautions:

• The risks outlined in the center's Fire Risk Assessment are actively monitored, with scheduled updates provided to the regulator regarding progress. In the event that any timelines are at risk of delay, the provider will promptly communicate these developments to the regulator to ensure transparency and accountability.

• Re-education sessions, led by the Person in Charge and ADoN, commenced on August 27th, focusing on the centre's updated evacuation policies and procedures, particularly for the largest compartment. All staff, except for two (1 on Maternity Leave, and 1 on Sick Leave), have completed the training and are now confident in their evacuation roles. The Person in Charge and ADoN have been conducting evacuation drills fortnightly to ensure that all staff are fully aware of identified risks, compartmentation, and evacuation procedures. Six evacuation drills have been conducted since the last inspection.

• The PiC and ADoN will continue fortnightly evacuation drills to reinforce staff confidence in evacuation procedures and their understanding of compartmentation risks. Ongoing reviews of evacuation times and staff performance will ensure continuous improvement.

• The PiC and the ADoN carried out a thorough review of all residents' dependency levels and associated Personal Emergency Evacuation Plans. Completed 23/08/2024 and ongoing monitoring.
• Five new FD60 fire doors have been ordered, and two FD30 fire doors will be upgraded to FD60s, with delivery expected by the end of October and installation scheduled for the first week of November. Once installed, these doors, along with concrete walls in the attic, will create additional 60-minute fire-rated compartments throughout the home. The complete scope of planned remedial work will result in a total of eight compartmentalized sections for enhanced fire safety.

• An extra staff member has been added to the night shift to ensure adequate personnel are available for evacuation and supervision, pending the installation of the fire doors. Completed 14/10/2024 and ongoing.

• A comprehensive fire door audit has been completed, identifying a scope of work that includes upgrading non-fire-rated ironmongery and glazed vision panels, as well as addressing any gaps and ensuring all doors close properly. Additionally, attic hatches will be upgraded to meet the required fire-rating standards.

• A detailed map outlining the compartments will be finalized once the FD60 doors are installed, assisting staff and residents in navigating the evacuation routes. In the meantime, a temporary map highlighting the current compartments is available for staff and residents near the fire panel while we await the completion of the detailed color-coded maps.

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:

• Post inspection the PIC/ADON have completed a review of the care plans identified during the Inspection to ensure they adequately reflect the needs of each individual resident. This review has been used as training for all nursing staff to ensure they are fully aware of the information required to direct safe and appropriate care for all residents. Completed 23/08/2024.

• Each resident has a named nurse in the center. All care plans will be reviewed to ensure that any identified gaps are addressed and to ensure that care plans are in place to support residents assessed needs. Completed 30/09/2024 and Ongoing

• A weekly care plan audit will be conducted by the Person in Charge/ Assistant Director of Nursing/ CNM. This audit will involve a thorough review of all residents' care plans to ensure they accurately reflect the outcomes of comprehensive assessments. The focus

will be on ensuring that all care plans are personalized, clearly documented, and contain specific interventions tailored to meet each resident's assessed needs. Any gaps or unclear interventions identified in the care plans will be addressed immediately. An action plan will be developed to resolve these issues, and it will be continuously reviewed to ensure that the care and welfare of resident's are appropriately documented and up to date. Ongoing.
• All Nursing Staff will receive additional support, and where necessary training from the CNM/ADON/PiC in respect of care planning and assessment. Completed and ongoing.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

Currently, twin bedroom 55 is occupied by one resident and has remained single-occupancy for over two years, with no plans to reintroduce dual occupancy. This arrangement ensures the resident's rights to privacy and dignity are respected.
We have discussed potential redesigns with the resident, who has expressed a preference to retain the room as it is during her stay. Consequently, any reconfiguration of this space will only be considered once it becomes vacant, preventing any disruption to the current resident, who is content with the existing arrangement.

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.	Substantially Compliant	Yellow	18/10/2024
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.	Substantially Compliant	Yellow	31/12/2024
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the	Not Compliant	Orange	18/10/2024

	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	18/10/2024
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	Orange	08/11/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	15/11/2024
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.	Not Compliant	Orange	30/11/2024
Regulation 28(1)(c)(ii)	The registered provider shall make adequate	Not Compliant	Red	27/08/2024

	arrangements for reviewing fire precautions.			
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.	Not Compliant	Red	14/10/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	14/04/2025
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	29/09/2024
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	Substantially Compliant	Yellow	18/11/2024

	the designated centre.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	23/08/2024
Regulation 34(2)(f)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant of the outcome of the review.	Substantially Compliant	Yellow	23/08/2024
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	23/08/2024
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	30/04/2025