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

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| Name of designated centre: | New Houghton Hospital |
| Name of provider: | Health Service Executive |
| Address of centre: | Hospital Road, New Ross, Wexford |
| Type of inspection: | Unannounced |
| Date of inspection: | 25 April 2024 |
| Centre ID: | OSV-0000603 |
| Fieldwork ID: | MON-0043345 |

## About the designated centre

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

New Houghton hospital is situated in the town of New Ross. The building was erected in 1936 and became the fever hospital for the counties Waterford, Wexford, Carlow and Kilkenny. In 1984 the building became a care of the older person's facility. While there have been many changes, renovations and some improvements since then the design and layout of the premises is largely reflective of a small hospital from the period in which it was built. The registered provider of the centre is the Health Service Executive (HSE). The centre is registered for 42 residents over the age of 18 years, both male and female for long term care. Services provided include 24 hour nursing care with access to community care services via a referral process including, speech and language therapy, dietetics, physiotherapy, occupational therapy, chiropody, dental, audiography and opthalmic services. All admissions are planned. Residents and relatives are welcome to visit the site in advance of the placement. Residents being admitted will have been assessed by the Geriatric Assessment team and placed on a waiting list for admission. Once a bed becomes available the resident and or relative is informed and is requested to arrive to the unit before 4pm Monday to Friday. The hospital accepts all levels of dependency from level 1 (full dependency) and including residents living with dementia. The services are organised over two floors with 21 residents accommodated on each floor with a passenger lift provided. Residents' accommodation on the ground floor comprises of four, four-bedded rooms, one three-bedded room, one twin-bedded room, and one single-bedroom (end of life suite) with adjacent family/community room. All bedrooms have hand washing facilities. Residents' accommodation on the first floor also consists of four, four-bedded rooms, one three-bedded room, one twin-bedded room, and one single-bedroom (end of life suite) with adjacent family/community room. There is access to an outside suitable secure garden area.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 42 |

## 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 |
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| Thursday 25 April 2024 | 10:00hrs to 18:15hrs | Niall Whelton | Lead |
| Thursday 25 April 2024 | 10:00hrs to 18:15hrs | Aisling Coffey | Support |

## What residents told us and what inspectors observed

This was an unannounced inspection to monitor compliance with the regulations made under the Health Act 2007 (as amended) and to inform decision making regarding the renewal of the registration for the designated centre. The inspectors were met by a clinical nurse manager (CNM), who facilitated the inspection. This inspection included a focused review of the premises and fire precautions. The centre is registered for 42 residents and with all beds occupied on the day of inspection.

New Houghton Hospital is within an older two storey building on a healthcare campus that accommodates several health and social care cervices in the town of New Ross. There are a number of external buildings housing ancillary purposes; laundry, maintenance, a boiler house, generator and general storage.

The centre comprises two units, one at first floor with female residents known as the Brandon unit and one at ground floor with male residents known as the Abbey Unit. There are also ancillary accommodation at ground floor including the kitchen, staff facilities.

During the walk-through of the centre, the inspectors observed that the centre was clean with the general fabric of the building in good condition.

On entering the centre, there is a large entrance lobby which has the stairway and lift to the upper floor. Just inside the door, to the right, there was a communal seating area, comprising a piano, sofa, armchair and a large coffee table, with a further armchair to the right. The inspectors observed staff and visitors walking through this area when entering the centre. While it was nicely decorated, inspectors did not see it being used by residents. The entrance to the ground floor unit, The Abbey was from the entrance lobby; this led to a corridor containing the ancillary rooms such as administration office, PIC office and also led to the kitchen. The corridor also led to the main bedroom corridor off which all the ground floor bedrooms and the day room opened on to. The day room had a retractable folding partition and this was not secured when opened. The ground floor day room provided access to the outside space for residents.

At first floor, there was a main bedroom corridor providing access to all bedrooms. There was a sitting room on the bedroom corridor and a dining room accessed through the lobby to the stairs. There was a coded lock on the dining room door.

There was three means of escape from the upper floor, one of which led to a raised concrete ramp, which allowed bed evacuation. The remaining escape routes from the upper floor was by way of two escape stairways. There were six evacuation mats in a box in one stairway and staff were awaiting training in their use. Staff

confirmed to inspectors that if the exit to the ramp was unavailable, there was no means to assist residents down the stairs.

Externally, there was a pleasant garden area accessed directly from the ground floor day room. The door leading to the garden had a coded lock. The outdoor space was nicely landscaped and had raised plant beds and pathways leading through the garden. There was a poly tunnel in the adjacent area, which was available for residents if they wished to use it. One of the pathways led through a pergola area covered in trailing planting. Elements of the garden area were not appropriately maintained; on entering the garden, the inspectors saw two timber posts which were damaged and were sharp to touch. This posed a risk to residents as they were positioned where a resident may place their hand for support. An immediate action was issued and the risk was addressed during the inspection. There were further timber posts which and raised plant beds in poor repair. The inspectors noted the garden was not being used by residents, although the weather was fine.

Overall there was a pleasant atmosphere in the centre. Most residents were up and about and seen to enjoy activities in the day spaces. Staff interactions were kind and staff were seen chatting to residents. Visitors were seen coming and going throughout the day.

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

The management systems in place were not sufficiently robust to recognise and respond to risk to residents' safety. Known risks associated with the evacuation strategy from the upper floor were not being managed. Urgent assurances were required from the provider regarding risks to residents safety due to inadequate arrangements for evacuating all residents from the upper floor, and lack of training in the use of recently procured evacuation aids. Action was required under Regulation 23; Governance and management, Regulation 17; Premises and Regulation 28; Fire Precautions

The Health Service Executive (HSE) was the registered provider for New Houghton Hospital. There was a senior HSE manager nominated to represent the provider. The person in charge had responsibility for the day-to-day operational management of the designated centre and was supported by five clinical nurse managers and a team of nurses, health care assistants, household, administration and maintenance staff.

The systems of responding to identified risk requires strengthening. For example one drill exercise identified the need for emergency lighting outside a ground floor exit, however this was not actioned. The risk of inadequate measures for evacuation

at first floor was repeatedly detailed in drill reports since January. While training was scheduled for the week following the inspection, the risk persisted since it was identified in January and the training had not been expedited. Owing to the risk to residents' safety, an urgent compliance plan was issued to the provider to implement control measures to manage the risk until adequate measures were in place to safely evacuate residents from the upper floor. The fire safety management plan, dated January 2024 included narrative, that if escape down the stairs is required, to use evacuation aids that are mounted on the wall beside the stairs. These evacuation aids were not yet in use and were stored in a box in one stairway.

The action required to configure Bedroom 5 on the Abbey Unit and Bedroom 4 on the Brandon Unit as three bedded rooms was not complete. While these rooms had three residents accommodated, the former fourth bed space was being used for storage and charging hoists.

The inspectors reviewed the communal space available for residents. An area inside the main entrance was being used as communal space. While it was decorated to a good standard, it did not afford residents privacy in their living space. It was a thoroughfare and was the main circulation route for staff and visitors to access the Abbey unit at ground floor and the Brandon at first. The lift and accommodation stairs was from this space. Discounting this area, there was insufficient communal space for residents on the ground floor. Furthermore, there was no private space for a resident to meet someone in private.

There were a number of rooms, used for the running of the designated centre, which were not within the red line (the line on the registered floor plan which sets out the extent of the registered designated centre), which included a records room at second floor, a maintenance shed, the boiler room and generator room.

## Regulation 23: Governance and management

The management systems in place were not sufficiently robust to ensure the service provided is safe, appropriate, consistent and effectively monitored, for example:

- Management systems were not effective to manage a known fire safety risk, regarding inadequate measures in place to ensure safe evacuation from the upper floor. An urgent compliance plan was issued to address this risk and to ensure adequate controls were implemented to manage the risk. This risk was identified in the previous inspection in January and still persisted
- Improvements were required with the identification of risk. Immediate action was required during the inspection to address inappropriate storage of oxygen cylinders and for a risk in the outdoor area where a damaged timber posts had sharp edges.

Judgment: Not compliant

## Quality and safety

Significant improvements were required by the registered provider to ensure adequate oversight of known risks in the centre. A risk regarding evacuation from the upper floor was identified during an inspection in January of this year, and documented by staff in fire drill reports, was not mitigated nor addressed within an appropriate time frame.

There was a fire safety management action plan, developed in April 2023 with further actions added in January 2024. The action plan was updated on the day of inspection to reflect the status of the actions. While a large number of the actions had been addressed, there were outstanding actions relating to fanlights above fire doors, an exit signage review, replacement of a number of heat detectors with smoke detectors, training on the use of evacuation mats in May 2024. The provider was exploring the option of upgrading the lift to an evacuation lift. Confirmation of this was received as part of the urgent compliance plan response, with an anticipated date for completion in July 2024.

In terms of fire containment, each floor was subdivided with thirty minute compartment boundaries for the purpose of progressive horizontal evacuation. While the kitchen and stairways were enclosed in sixty minute construction, each floor was not sub-divided into at least two sixty minute fire compartments to facilitate progressive horizontal evacuation and instead relied on thirty minute compartment boundaries. Fire doors throughout were mostly in good condition and had recently been upgraded. They were in good condition and fit well within the door frame. The inspectors saw tags on the fire doors which included the door number, fire rating of the door and the date of inspection. There was evidence that work had been completed to the fire doors; there was a white residue from the product used during the upgrade process and the door had not yet been painted.

There had been a leak to the main gas tank and temporary smaller tanks were put in place until the main tank was either repaired or replaced. There was no time line available for when this would be complete. It was confirmed to the inspectors that the gas shut off points within the kitchen were still functional in an emergency.

At the previous inspection, walls within some bedrooms had been damaged, leaving exposed plaster. This had been actioned and the provider had arranged for a perspex wall saver to an appropriate height in bedrooms to reduce damage to walls and to facilitate cleaning.

## Regulation 17: Premises

Action was required to meet the requirements of the regulation 17 and Schedule 6, for example;

- At the previous inspection, Bedroom 5 on the Abbey Unit and Bedroom 4 on the Brandon Unit, which are registered as three-bedded rooms on the floor plans and statement of purpose, were operating as four-bedded rooms. While they were now operating as three bedded rooms, further action was required to suitably configure the rooms for three residents. Tracking for the privacy curtain for the fourth bed space was still in place in one bedroom. The fourth bed space in both rooms was being used as a storage area and was not usable space for the three residents living in the room.
- Upon review of the communal space, the area inside the main entrance was not a suitable communal space for residents. Discounting this area, there was insufficient communal space for residents in the designated centre, in particular at ground floor. Furthermore, there was no private space for a resident to meet someone in private
- A shared twin room, did not have a privacy curtain at the end of the bed, resulting in a lack of privacy where the other resident in the room accessed their bed space
- Areas of the garden were in poor repair, in particular timber posts around the raised patio area and some furniture had paint which was flaking off
- a manhole in the garden area was not level with the path and was a trip hazard
- The inspectors observed areas of damp to some window reveals, where paint and plaster were flaking from the wall, resulting in dust deposits; these were evident in Room 1 and the end of life room at ground floor
- The day room had a retractable folding partition and this was not secured when opened. This was a risk where a resident may lean on it for support and was not included in the risk register
- There were damaged floors to a number of areas; it was difficult to ensure they were effectively cleaned
- Further to the upgrade works to fire doors, the doors had not been painted and were unsightly

Judgment: Not compliant

## Regulation 28: Fire precautions

The inspectors were not assured that the registered provider had taken all reasonable actions to ensure that residents were appropriately protected from the risk of fire. The absence of adequate means to evacuate residents on the stairways and training in the use of procured evacuation aids created a risk to the safety of residents. An urgent compliance plan was issued and the provider's response did provide assurance that the risk was adequately addressed. The provider provided assurance that until the training for the evacuation aids was complete, an additional staff member was scheduled for night time to carry out hourly checks to enhance

fire prevention. Training on the use of the evacuation aids was scheduled for 02 May. Further to the training, the provider is required to review the number of evacuation aids in place to ensure there is a sufficient supply for effective evacuation down the stairs in required.

The measures in place to safely evacuate residents from the upper floor required action. There were three escape routes from the first floor; one was along a raised concrete ramp which allowed the beds to be evacuated. The other two escape routes were vertically along two separate stairways. At the time of inspection, there was no means to evacuate 19 residents from the upper floor, in the scenario where the exit to the ramp was not available. The provider had procured six evacuation mats and these were in a box within one stairway. Staff spoken with knew there was a risk associated with vertical evacuation and had not been given information on how the risk was being managed. They had not been informed how to evacuate residents down the stairs if required; the only route available was the exit leading to the concrete ramp.

While fire safety training was being provided to staff, training had not been delivered to staff for the use of the new procured evacuation mats. Staff spoken with were generally knowledgeable on the evacuation procedures, however confirmed they did not know how to use the evacuation aids and expressed concerns regarding evacuation of residents from the upper floor. This was also recorded in the fire safety drills. Staff and management spoken with, were not clear on the purpose of one of the utility emergency shut down points in the kitchen.

The procedures to follow in the event of a fire were not clearly displayed. Fire action notices were displayed, but did not highlight the evacuation procedure in each floor. There was a different evacuation procedure at ground and first floor.

The provider was not taking adequate precautions against the risk of fire, nor adequately reviewing fire precautions, for example

- The inspectors observed poor practice with regard to the storage of oxygen cylinders. Unsecured oxygen cylinders were stored in a plastic box in the nurse station on each floor. Empty, full and out of date cylinders were stored together. These were removed during the inspection
- The fire door to the staff changing room was propped open; this meant that when the fire alarm activated, the fire door would not close to contain smoke and fire.
- The inspectors observed a hoist battery being charged within a multi occupancy bedroom, introducing an unnecessary risk within residents' bedroom
- The lift motor room had a foldable plastic table stored against the lift machinery equipment posing a risk of fire and there was a trolley blocking access to the extinguisher within the room
- The lint screen in the laundry dryer had not been cleared and had accumulated a thick layer of combustible lint. The checklist to show it was being cleared was not up-to-date

- The pilot light in the kitchen was left on while the kitchen was in operation. There was no checklist or procedure to ensure the pilot lights on cooking equipment was turned off when the kitchen was not in use, nor was this risk on the risk register
- The store room, known as 'the Shop' had electrical panels at a high level. The position of storage shelving and the proximity and distance from electrical panels required risk assessment to determine appropriate controls to mange the risk.

The provider was not ensuring an adequate means of escape was provided, including emergency lighting, for example:

- The threshold of the exit by Room 5 was not level and was identified in a drill record as being difficult to manoeuvre an occupied bed over the threshold. Staff demonstrated this; it was feasible to manoeuvre an empty bed, however staff reported it was more difficult when a bed was occupied
- Some areas of the external escape routes did not have adequate coverage of emergency lighting to ensure safe escape to the assembly points. The emergency light over the main entrance was not working
- The provision of escape signage was not adequate and required review. This was an action captured in the providers own fire safety management action plan in 2023. The ground floor had been completed, the first floor was awaiting review.

Action was required to ensure adequate containment and detection of fire, for example;

- Each floor was subdivided with sub-compartment boundaries, however there were no sixty minute compartment boundaries for progressive horizontal evacuation. The minimum requirement for nursing homes, would be to have each floor subdivided into at least two sixty minute compartments
- Further assurance was required regarding the glazing between the ground floor nurse station and the adjacent escape corridor, to ensure it provided adequate containment of fire
- There was a hole in the plasterboard on the wall between the stairway and lobby at first floor, thus breaching the fire resistance of the wall
- The action plan for fire safety management plan, included an action to review of the fanlights over some fire doors to determine if they provided adequate fire containment; this action was outstanding
- The staff room was fitted with a heat detector, and not a smoke detector for early detection and warning of fire. this was an outstanding action from the fire safety management plan
- The housekeeping room and first floor was not fitted with fire detection

Notwithstanding the upgrade works to the fire doors throughout the centre, some action was required regarding maintenance of the fire doors. There was a number of doors where the latch did not engage when the door closed, which would result in

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| the fire door being left ajar. There was also an excessive gap beneath a compartment fire door which would allow the spread of fire and smoke. |
| 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 New Houghton Hospital OSV-0000603

## Inspection ID: MON-0043345

## Date of inspection: 25/04/2024

**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:<br><br>• As an immediate response to the last HIQA inspection on 9th January 2024, a compliance plan on fire precautions was submitted to HIQA on 26th February 2024, with additional information submitted 8th March 2024, confirming the compliance actions relating to fire precautions would be completed at latest by 2nd May 2024.<br>o Online fire safety training to be completed for all staff– completed February 2024<br>o Site-specific in person fire evacuation training to be completed for all staff – completed February 2024<br>o Purchase of 6 X ski-sleds and specialist training on the use of same for all staff – completed 2nd May 2024<br>o Unannounced evacuation drills to be scheduled monthly – in place February 2024<br>o Follow up meeting with HSE Fire Officers to review and progress fire safety plan – completed 13th March 2024<br>• HIQA subsequently carried out a further unannounced inspection on 25th April 2024 (date of this report) which was during the timeframe of the pre-existing accepted compliance plan which was due for completion on 2nd May. It is confirmed all agreed actions were completed in line with the accepted timelines from the January 2024 inspection.<br>• There is now a tertiary evacuation method in place for the first floor and a further fourth method of evacuation due to come on stream in July 2024 (subject to contractor). These are as follows:<br>o Progressive Horizontal Evacuation to Place of Safety (Existing)<br>o Vertical Evacuation down Concrete Evacuation Ramp (Existing)<br>o Use of specialist ski-sleds and requisite training to support stairs evacuation (as of 2nd May 2024)<br>o Upgrading of passenger lift for use as evacuation lift (expected July 2024 completion subject to contractor. This has now been extended out to September 2024, due to Contractor awaiting parts) | |

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| • Immediate action was carried out during inspection to remove additional oxygen cylinders and removal damaged timber posts from garden.<br>• Multi-disciplinary environmental walk around is being scheduled for June 2024 and any findings will be actioned as a matter of urgency. |

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| Regulation 17: Premises | Not Compliant |

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

• The tracking for the fourth bed space in a 3 bedded room has now been removed and only items for use by the 3 residents in that room such as person-specific specialist seating. The mobile hoist has now been removed from the 3 bedded room and stored in an alternative currently unused room.
• The ground floor reception area in the lobby has long been used as a comfortable communal space for residents to sit and meet with each other, or with family and friends, and was recently upgraded in 2022. The information technology room will be re designated and upgraded to meet the centre's required communal space requirement.
• An urgent maintenance request has been submitted to add an additional privacy curtain to the shared twin room and a mobile screen is being used in the interim to support the resident's privacy.
• The garden area is under review – request for maintenance have been logged and this area will also be reviewed as part of the scheduled environmental walkaround.
• A maintenance request has been logged to review and repair the damp observed at the window reveals.
• The folding partition wall is now secured closed and there is additional signage in place to advise of safe operation.
• A flooring review has been undertaken and quotation awaited to plan for the repair and upgrade of flooring as required.
• The upgrade works to the fire doors, including remedial decoration where ay works were required has been completed downstairs and are ongoing upstairs.

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| Regulation 28: Fire precautions | Not Compliant |

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

• As an immediate response to the last HIQA inspection on 9th January 2024, a compliance plan on fire precautions was submitted to HIQA on 26th February 2024, with additional information submitted 8th March 2024, confirming the compliance actions relating to fire precautions would be completed at latest by 2nd May 2024.

o Online fire safety training to be completed for all staff– completed February 2024
o Site-specific in person fire evacuation training to be completed for all staff – completed February 2024
o Purchase of 6 X ski-sleds and specialist training on the use of same for all staff – completed 2nd May 2024
o Unannounced evacuation drills to be scheduled monthly – in place February 2024
o Follow up meeting with HSE Fire Officers to review and progress fire safety plan – completed 13th March 2024
• HIQA subsequently carried out a further unannounced inspection on 25th April 2024 (date of this report) which was during the timeframe of the pre-existing accepted compliance plan which was due for completion on 2nd May. It is confirmed all agreed actions were completed in line with the accepted timelines from the January 2024 inspection.

• There is a further session of specialist ski-sled training scheduled for July 2024 to capture those returning from long-term leave.
• Fire drills are now incorporating the use of ski sleds to support stairs evacuation. Further to the commencement of the updated fire drills, a review was undertaken of the number of ski sleds in use and 2 additional ski mats are being sourced as supplementary aids while awaiting the upgrade of the passenger lift (scheduled for completion July 2024, subject to contractor). This will allow for 4 ski sleds at each stairwell. A further review will be taken once the evacuation lift is factored into the evacuation strategy and drills as this will support bed evacuation to the ground floor.

• Additional signage has been installed in the kitchen to identify the emergency utility shut down points and this has also been highlighted to the kitchen staff to ensure their familiarity with same.
• Evacuation procedures and fire action notices are displayed prominently on both floors.
• All non-essential oxygen cylinders have been removed from the centre and the requisite cylinders are being secured with brackets to the walls in line with best practice.
• The fire door to the staff changing room is now fitted with an automatic door guard which will automate closure in case of a fire alarm.
• As part of fire prevention practice, the charging of the mobile hoist will be reviewed dynamically to ensure it is being charged in the most suitable area – this may be an area that is unoccupied such as an empty room or in an area with additional supervision such as the nurse's station.
• All non-essential equipment has been removed from the lift motor room.
• The emptying of the lint screen is now on the daily cleaning schedule for the laundry and the checklist for same is on the audit schedule.
• Updated signage and an "end of day" checklist is now in place in the kitchen to highlight importance of turning off the pilot lights on equipment. The checklist for same is on the audit schedule.
• The requisite periodic electrical inspection (due June 2024) has been arranged and will include a review of the store room/Shop electrical panels.

• The threshold of the exit across from Room 5 has been reviewed and repaired to provide better egress from the room when transferring a bed in or out of the exit.
• The service provider for emergency lighting and escape signage is scheduled for their quarterly review and the coverage of emergency lighting and signage will be highlighted

for review and repair/upgrade where required.
• The centre has a well-maintained back-up generator to minimize the impact of any power interruption and ensure any evacuation procedure could be carried out with sufficient lighting.

• Exploratory works are to be carried out to review the existing compartment boundaries and to upgrade if required to meet the requirement for two sixty minute compartments on each floor. The timeline for the exploratory works and to allow for any required upgrade is 31/12/2024.
• The glazing in the ground floor nurse station is being reviewed to ensure compliance and will be upgraded or removed if insufficient.
• The hole in the plasterboard has been logged with maintenance and will be addressed as soon as possible.
• The review and any requisite upgrade of the fire doors is ongoing will include a review of the fanlights to ensure they provide adequate fire containment, a review of the latches and a review of the gaps beneath compartment doors. Any requisite works will be carried out to upgrade same if not to standard.
• The staff room and housekeeping room on the first floor will be fitted with the appropriate detectors as a matter of urgency.

## 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(1) | The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3. | Not Compliant | Orange | 30/09/2024 |
| Regulation 17(2) | The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6. | Not Compliant | Orange | 30/07/2024 |
| Regulation 23(c) | The registered provider shall ensure that management systems are in place to ensure | Not Compliant | Orange | 31/07/2024 |

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| | that the service 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 | 31/12/2024 |
| Regulation 28(1)(b) | The registered provider shall provide adequate means of escape, including emergency lighting. | Substantially Compliant | Yellow | 30/09/2024 |
| Regulation 28(1)(c)(i) | The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services. | Substantially Compliant | Yellow | 31/12/2024 |
| Regulation 28(1)(c)(ii) | The registered provider shall make adequate arrangements for reviewing fire precautions. | Not Compliant | Orange | 31/07/2024 |
| Regulation 28(1)(d) | The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire | Not Compliant | Orange | 13/06/2024 |

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| | prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire. | | | |
| 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 | Orange | 13/06/2024 |
| Regulation 28(2)(i) | The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. | Not Compliant | Orange | 31/12/2024 |
| Regulation 28(2)(iv) | The registered provider shall make adequate arrangements for evacuating, where | Not Compliant | Red | 29/04/2024 |

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| | 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. | Substantially Compliant | Yellow | 30/06/2024 |