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:	St Paul's Nursing Home
Name of provider:	Blockstar Limited
Address of centre:	St Nessan's Road, Dooradoyle, Limerick
Type of inspection:	Unannounced
Date of inspection:	13 April 2023
Centre ID:	OSV-0000433
Fieldwork ID:	MON-0039764

About the designated centre

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

St. Paul's Nursing Home is a purpose-built designated centre and has been in operation since 1963. The nursing home was opened and operated by the Bons Secour De Troyes until 2010 when it was purchased by Blockstar Limited, who are the current registered providers. The centre is registered to accommodate 57 residents in 52 bedrooms – one three bedded room, three two bedded rooms (two with en suite facilities) and 48 single bedded rooms (seven with en suite facilities). The centre provides 24-hour residential care for both female and male residents and provides general long-term care, palliative care, convalescent care and respite care. The centre is registered to care for persons over the age of 18 but most residents are over 65 years of age and can cater for residents assessed as being from low to maximum dependency levels' as per the modified Barthel Index.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	57

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 13 April 2023	10:15hrs to 20:30hrs	Mary O'Mahony	Lead
Friday 14 April 2023	10:00hrs to 15:45hrs	Mary O'Mahony	Lead
Thursday 13 April 2023	10:15hrs to 20:30hrs	Niall Whelton	Support

What residents told us and what inspectors observed

The overall feedback from residents and relatives was that St Paul's Nursing Home was a comfortable place to live where residents were known to staff and felt safe. Inspectors spoke with the majority of residents during the two days of inspection and to five residents in more detail. Residents felt that their rights and choices were respected. Survey results were seen which confirmed that they were satisfied with the care and accommodation. Residents said that staff were kind and caring and available to listen to any concerns they might have.

On arrival inspectors were met by the person in charge and guided through the infection prevention and control measures in place. Following an introductory meeting, inspectors walked around the premises and the external grounds with the person in charge and two of the directors.

Inspectors observed a relaxed and happy atmosphere in the centre throughout the inspection days. Residents appeared well dressed according to their preferred style and it was apparent that they had regular access to the hairdresser. Staff interactions were seen to be kind and attentive towards residents. Residents were observed going out to external appointments with family and staff members.

There were a variety of communal areas in the centre such as the sitting rooms, dining rooms and a nice visitor's room where residents and their visitors congregated. Residents were also seen using the enclosed gardens and the chapel. The large chapel was very popular according to residents and they found the mass and daily rosary "peaceful". Residents were seen to come and go from the chapel during the day. The hair salon was in use on the day of inspection and there was general praise for this facility.

The centre was laid out over three floors, with resident bedrooms and day room accommodation on all floors. There was lift access between floors. Previous laundry chute access between each floor and the laundry had been closed off now as part of the fire safety works which were ongoing. A number of fire safety risks were identified during the premises walkabout. For example, fire safe doors (doors especially designed to contain smoke or fire for periods of between 30 minutes to one hour) were not closing properly, certain fire safe doors which should have been closed were kept open, there was no door to the laundry, which was a high risk area, and there were visible holes in the ceiling where services or fire detection systems had been relocated. This meant that fire and smoke containment could not be assured in the event of a fire. These and a number of other issues related to fire safety were discussed with the provider and in some instances immediate action was taken as outlined in detail under Regulation 28.

Some residents said that they liked to sit in their bedrooms during the day and attend activities whenever there was music, art or bingo. Residents had a selection of books, a clock, TV and radio in each room. They were seen to watch their choice

of programme or read the daily papers. One man enjoyed watching the racing festival which was on at the time of inspection. Residents said the bedroom accommodation was comfortable and the storage facilities for their personal possessions was sufficient. The inspectors saw there were no complaints about missing clothes which were washed on site in the spacious laundry. However, some of the older furniture such as wardrobes and chests of drawers, were in a poor state of repair, as doors could not be closed or locked due to the age of the item or where it had become warped. This was further described under Regulation 17, Premises.

All residents had the choice of having their meals in the large, newly decorated dining room on the ground floor, or in the communal rooms on each of the three floors, or alternatively in the privacy of their bedrooms. Staff were available to facilitate the residents' choice and provide assistance and support where necessary. New tablecloths and new curtains had been purchased for the dining room and each table had a printed menu for the day. Residents said this was "a great idea" as they sometimes found it difficult to remember the choice they had made the previous day. On the first day of the inspection there was a special party menu on display to celebrate one resident's birthday. This indicated a thoughtful and person-centred approach to the individual residents. One male resident described the place as "very good" and he felt he was supported to continuously improve. A number of residents were known to staff prior to admission and they said this made the transition to long term care a bit easier as they could talk about "familiar people and events".

Residents told inspectors that they were confident that any concern or complaint would be resolved. They attended resident meetings on a three monthly basis. Some residents were members of the residents' committee where they could voice their concerns or their views about aspects of the centre. The centre was home to a small number of residents under the age of 65 and inspectors met with those residents during the inspection. From the documentation seen and from talking with their individually assigned staff it was apparent that they were receiving attentive clinical and social care. Arrangements were in place to provide care and support to those residents in line with their assessed needs which included access to external outings and events.

The activities schedule was displayed on each of the three floors which enabled residents to choose activities in line with their likes and capability. On the day of inspection, a large group of residents were seen to attend and enjoy a chair based exercise session with an external facilitator. Residents were observed laughing and singing along with the familiar songs. They told inspectors that this was weekly event and they were seen to have a good rapport and fun with the facilitator. There was a steady stream of visitors throughout the two days and those spoken with expressed satisfaction with all aspects of care. Visitors said they were "always welcomed" and they were encouraged to bring in some favourite food items for those with diminished appetites.

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 on the quality and safety of the service being

delivered. The levels of compliance are detailed under the individual regulations.

Capacity and capability

This was an unannounced risk inspection conducted by two inspectors of social services to assess compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The provider had applied to renew the registration of the centre as this was due to expire in August 2023. Overall, findings of this inspection were that St Paul's Nursing Home was generally a good centre, where residents received a high standard of care by staff that were kind and respectful. Nevertheless, responsive, immediate and timely action was required, particularly in the area of fire safety management, and action was required in infection control processes, record keeping and safe storage of same, premises and care planning, which are detailed under the relevant regulations in this report.

Significant regulatory non-compliance was identified on previous inspections with regard to fire safety and the premises. Consequently, the Chief Inspector renewed the registration of the centre in 2020 with two additional restrictive conditions attached to the centre's registration. The purpose of those conditions were to improve the availability and accessibility of sanitary facilities for residents and to take the necessary action to ensure residents were adequately protected from the risk of fire. On this inspection, inspectors found the registered provider had complied with condition 4 in relation to increasing the toilet and shower availability, however condition 5 of the registration in relation to addressing fire safety management issues had not been complied with. While the provider had applied for an application to vary the date by which the works would be completed, this was not acceptable in view of the very high risk to residents associated with fire safety breaches, and the length of time that had elapsed since the condition was applied. Additionally the provider was not managing known fire safety risks in areas adjacent to the registered designated centre which would affect the designated centre, some of which were identified in the centre's own fire safety risk assessment. Inspectors issued two immediate actions in fire safety management which were complied with. The fire safety issues requiring action were described in detail under Regulation 28 in the quality and safety section of this report

The centre was operated by Blockstar Limited which was the provider of the service. There were three directors in the company one of whom acted on behalf of the provider in relation to regulatory matters. The governance structure in place set out clear lines of authority and accountability. The person in charge was supported by the group regional manager and a strategic manager. On site, the person in charge was supported by two clinical nurse managers who deputised in the absence of the person in charge. There was a team of nursing, healthcare assistants, household, kitchen, administration and maintenance staff in place.

Inspectors found that there were effective communication systems in place. These included daily handover reports, residents' daily communication sheets and minutes of meetings with staff from all roles. Comprehensive management systems included a schedule of audits in areas such as infection control, medication management and infections had been developed. Key performance indicators (KPIs) were recorded and trended in areas such as wounds, restraint and complaints. Written policies and procedures were available, as required under Schedule 5 of the regulations.

On the days of inspection staffing numbers and skill mix of staff appeared appropriate to meet the needs of residents, with due regard to the layout of the centre over three floors. The person in charge stated that staff nurses had received specific training where intensive needs had been identified for residents. This was confirmed by staff spoken with. Inspectors examined staff training records which confirmed that all staff had up-to-date training to support them in their respective roles, such as manual handling, nutrition, end of life and the prevention of abuse. However, additional training was required in relation to the use of evacuation aids, which was addressed under Regulation 28 on fire safety.

Inspectors found that records and additional documents required by Schedule 2, 3 and 4 of the regulations were available for review. However, archived files and some current files were not stored in a manner that was safe and easily accessible. A sample of staff personnel files were reviewed. Actions that were required in relation to meeting the regulatory requirements for staff documentation were highlighted under Regulation 21, records. Vetting clearance certificates, in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 and 2016, were in place for all staff prior to commencement of employment. There was a complaints management system in place and all complaints were acknowledged in writing.

Registration Regulation 4: Application for registration or renewal of registration

The requirements of the regulator related to renewal of registration were fulfilled.

Judgment: Compliant

Registration Regulation 8: Annual fee payable by the registered provider of a designated centre for older people

The annual regulatory fees were paid in a timely manner.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge fulfilled the requirements of the relevant regulations. She was well known to residents and relatives and was clinically knowledgeable. She was aware of residents' needs and the responsibilities of her role as person in charge.

Judgment: Compliant

Regulation 15: Staffing

Inspectors reviewed the staff roster on both mornings of inspection and saw that it corresponded with the number and skill mix of staff on duty.

Communication with residents and staff confirmed that the staffing levels were sufficient to meet the needs of residents.

There were nursing staff on duty over the 24 hour period.

Judgment: Compliant

Regulation 16: Training and staff development

Staff training records indicated that staff had attended appropriate and mandatory training such as, manual handling, prevention of abuse, infection control, and dementia care. Staff said that training was easily accessible. New staff spoken with confirmed that they had attending a range of courses including induction training.

Nursing staff had evidence of updated medicine management training and catering staff had attended food safety training courses.

Annual appraisals were undertaken. Copies of these were seen in a sample of staff files reviewed.

Nevertheless, aspects of fire evacuation training required review as addressed under Regulation 28.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents was maintained in line with the requirements set out

under Schedule 3 of the regulations for the sector.

Judgment: Compliant

Regulation 21: Records

Records were not stored in a manner that was safe and accessible as required under the regulations:

This was evidenced by:

- Boxes of records were stored in a small archive room, half of which were stored without shelving, one box piled on top of the other. Confidential items from one box had fallen on the floor. There was a fire hazard in this archive room which had not been risk assessed or controls had not been put in place to ensure archived files were protected from a potential file. Additional boxes of records were stored in a similar manner in a second cupboard.
- Some resident information was stored in the entrance hall at reception in an open cupboard.
- Files of residents' information were stored in unlocked filing cabinets in open staff offices.
- A box and folder of financial details pertaining to residents were stored in an unlocked staff changing area, which also served as an office.
- Residents' files were stored in an unlocked filing cabinet, when checked by the person in charge, in an area that was not registered.
- In the sample of staff files reviewed there were gaps noted in the employment details of staff members. The regulations required a complete employment history to be maintained on file along with an explanation of any gaps in employment to ensure robust recruitment processes..

A number of these issues were addressed by the end of the second day.

Non compliance on record management was a repeat finding and the storage of records did not comply with the centre's own policy on the storage of such records.

Judgment: Not compliant

Regulation 22: Insurance

An up-to-date contract of insurance was in place as required by the regulations for the sector.

A copy was made available to inspectors

Judgment: Compliant

Regulation 23: Governance and management

Some management systems were not sufficiently robust to ensure the service was safe and appropriately and effectively monitored. More robust systems were required to ensure additional and more effective oversight. The outstanding issues referenced below, were described further under the specific regulations.

Oversight of fire safety management issues:

- The registered provider had failed to ensure that improvement works relating to fire safety were completed within the time lines required in the centre's conditions of registration.
- Additional training was required in the use of evacuation aids in view of the fact that the building was laid out over three floors.
- Oversight of fire safety issues required action and risk assessment as identified under Regulation 28.

Oversight of record management**:**

- Archived and current records were not safely stored and the archived files were not secure and easily accessible as required under the regulations. This was addressed under Regulation 21.

Oversight of care planning:

- Risk assessments were required to underpin some care plans particularly for those at risk of aspiration or choking. This was actioned under Regulation 5.

Oversight of premises issues:

- Issues requiring action in relation to premises were outlined under Regulation 17.

Oversight of infection Control:

- Some aspects of infection control required action as addressed under Regulation 27.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Contacts had been updated since the previous inspection and now contained details of fees and the room number that each resident would occupy.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose was reviewed on an annual basis.

It outlined the governance arrangements, the ethos of care, the complaints process and the arrangements for residents to be involved in their care plans and activity provision.

Judgment: Compliant

Regulation 4: Written policies and procedures

The policies required under Schedule 5 of the regulations were available in the centre.

These were seen to have been updated every three years or when there were new developments, such as, the addition of COVID-19 guidelines to relevant policies.

Nonetheless, inspectors found that the policy on record storage was not implemented and this was addressed under Regulation 21; records.

Judgment: Compliant

Quality and safety

Overall residents in St Paul's Nursing Home were found to be supported to have a good quality of life which was respectful of their wishes and preferences. There was timely access to healthcare services and appropriate social engagement, with a person-centred care approach established. A human rights-based approach was promoted and residents spoken with said that this approach was apparent to them in how they felt respected and acknowledged. Nonetheless, action was required to

ensure that all residents in the centre were safe. Inspectors found repeated non-compliance, identified during previous inspections of the centre, in relation to Regulation 28, fire precautions, some aspects of which required immediate action. Consequently, the registered provider had not fulfilled the requirements of condition 5 of the centre's registration. In addition, inspectors found that action was also required to comply with Regulation 27, infection control, Regulation 5, care planning and Regulation 17, premises under this dimension of the report.

Care plans in general were detailed. They were maintained on the computerised system and were updated on a four monthly basis. Members of the multi-disciplinary team, for example the physiotherapist had inputted advice for staff in providing best evidence-based care. There was evidence seen that residents had been consulted in the development of their care plans. General practitioners, (GPs) visited the centre weekly or as required and were described as available and supportive. Systems were in place for referral to specialist services. On admission a comprehensive assessment was carried out for each resident which was then updated under individualised headings for each identified need. Despite elements of good practice there were some aspects of the sample of care plans reviewed that required action, as highlighted under Regulation 5.

The registered provider was in the process of upgrading the premises on an ongoing basis and had employed a maintenance team who were responsible for this. Flooring had been replaced in a number of areas, sinks and sink units had been replaced, painting had been renewed and shower rooms had been installed. However, despite this, a number of other premises issues were found to require action, as outlined under Regulation 17.

Since the previous inspection, identified issues with fire doors had been repaired. The emergency lighting system in the building was being upgraded and inspectors saw the new units fitted throughout. The fire alarm system was a zoned system and was at full capacity. There were a number of areas throughout the building which were not provided with adequate detection of fire. The provider immediately arranged for domestic type detectors to be installed in the interim until a sustainable solution could be determined to provide additional detection. The provider arranged for the fire alarm contractor to come on site during the inspection, and confirmed plans to have the system reviewed early the following week. The type of system relies on staff to search a zone to identify the location of the fire. Fire doors to bedrooms are not fitted with automatic closing devices, therefore relying on staff to close the door. Where fire doors to bedrooms are routinely left open, smoke may spread into those bedrooms while the resident is waiting to evacuate. This risk was not risk assessed.

The fire alarm system, emergency lighting and fire fighting equipment were being serviced at the appropriate intervals. The provider had assessed the evacuation requirements of residents and these were in the form of a personal emergency evacuation plan (PEEP) for each resident. The provider had also adopted a simple system of colour coded tags outside bedroom doors to alert staff during evacuation of the dependency of the residents in the room and the evacuation aid required. To support vertical evacuation, evacuation chairs had been procured and placed within

each stairway. However, not all staff had received training in the use of the evacuation chairs. Additionally all beds were fitted with a ski sheet under the mattress. Inspectors found that improvements were required to ensure the ski sheet was correctly secured to the bed, as some were observed to be not fitted appropriately. The person in charge immediately arranged for all ski sheets to be checked. Further fire safety issues were highlighted under Regulation 28.

The safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. However, since the COVID-19 pandemic training courses were being delivered on an on-line forum. The person in charge stated that there were plans to revert to classroom based training in the areas of elder abuse and dementia care training to ensure staff retained the training advice and could discuss real life scenarios from their experience in the centre.

Residents' nutritional and hydration needs were met. Home baking was available and the kitchen was well stocked, clean and well equipped. Systems were in place to ensure residents received a varied and nutritious menu based on their individual food preferences and specific requirements such as, gluten free diet or modified diets. Residents' nutritional status was assessed monthly and a dietitian was consulted if there was any evidence of diminished food intake or risk of malnutrition. Inspectors found that food had been fortified, following advice from the dietitian where it was found that residents' had lost weight. This was an ongoing project to ensure good nutritional intake and the maintenance of a healthy weight.

It was evident that residents were consulted about the running of the centre, formally, at residents' meetings and informally through the daily interactions with the management and care team.

Regulation 13: End of life

A holistic assessment of residents' end-of-life wishes and support needs was completed on admission to the centre. Decisions regarding resuscitation status were made through a multi-disciplinary team approach in consultation with the resident and, where appropriate, their relatives.

Judgment: Compliant

Regulation 26: Risk management

The risk management policy met the requirements of the regulations.

Where non-compliance was found with aspects of risk management it was actioned under Regulation 23: governance and management.

Judgment: Compliant

Regulation 27: Infection control

The infection prevention and control management in the centre did not fully comply with the requirements under Regulation 27. Action was required to ensure that infection prevention and control procedures were consistent with the national standards for infection prevention and control in community services as published by HIQA.

This was evidenced by:

- Both sluice rooms required a deep clean and in both sluice rooms the detergent holder for the bedpan washing machine was not usable as the chemical appeared to have dried up in the container. This presented a risk of incomplete sanitisation of bedpan and commode pans.
- A number of sinks in the bedroom areas were cracked and some of the wooden cabinets which housed these sinks were scuffed and broken. This presented a risk of bacteria being harboured in the cracks and ineffective cleaning due to the scuffed surface around the sinks.
- A number of outlets in the sinks were rusted and this prevented effective cleaning as above.
- The laminate on some lockers and chest of drawers was lifting, there was a risk that effective cleaning of these items was not possible because of the breached surfaces.
- Some sections of the centre such as the area under the stairs and the sacristy required cleaning.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Notwithstanding the actions taken during the inspection to address fire safety risks identified, further actions are required to ensure adequate precautions against the risk of fire and to ensure the safety of residents.

Immediate actions were required on the day of inspection to address the following risks:

- the absence of effective fire detection in areas of the designated centre
- an exit from the chapel was locked and the key to open it was not in the break glass unit adjacent to the door.

Adequate precautions were not being taken against the risk of fire:

- the arrangements for residents who smoke were not effectively managed. There was evidence of smoking in multiple areas. Suitable equipment was not available at the location, identified to inspectors, as the residents' smoking area. There was no call bell to summon assistance if required
- fire safety risks external to the designated centre, which may impact the safety of residents were not effectively managed
- fire doors were observed to be routinely either left open or propped open against the closing device
- the absence of automatic self-closing devices to bedroom doors had not been risk assessed
- storage arrangements in the centre were creating a fire hazard. For example, file boxes in the archive store were stacked on top of each other within a room containing electrical panels
- the area under the stairs in reception was not enclosed in fire rated construction and this area housed computer equipment, CCTV equipment and wheelchair storage. This area was not fitted with smoke detection
- there was a hoist battery on charge in a nurse station. This room was not fitted with fire detection
- the recommended periodic inspection report for the electrical installation had not been completed.

The arrangements for providing adequate means of escape including emergency lighting were not adequate:

- the rear exit from the chapel was locked and the key was not available in the break glass unit adjacent to it. This was addressed during the inspection. There was a plant and a bin obstructing the exit and a step on the threshold of the door; this would impede escape for residents with mobility impairments
- emergency lighting was not available outside some exits nor along routes leading to the assembly points. The emergency lighting system was being upgraded and would address this
- the escape corridor at ground floor was a long un-undivided corridor and was not effectively sub-divided to prevent the spread of smoke along its length.

The arrangements for containing fire were not adequate;

- high risk rooms were not provided with adequate containment of fire. The laundry room did not have a door and was not fire separated from the adjacent laundry store. The fire doors between the kitchen and residents' dining room were not closing correctly and one door was routinely left open. There was a hole in the wall between the kitchen and laundry room through which the gas pipe passed
- deficits to fire doors were observed. Some doors did not close against the latch, gaps were observed around the edge of doors and some were missing the smoke or heat seal. One door was warped and unable to close and the closing device to some was too strong. Fire doors to rooms (other than bedrooms) were noted to not have automatic closing devices and were found

open. For example, an office and residents' quiet room. A review of the fire doors is required to ensure they are effective to contain the spread of fire and smoke
- service penetrations were observed in fire rated construction which were not adequately sealed to ensure containment of fire
  Further assurance is required from the provider regarding the containment of fire between the chapel and the first floor; it was not clear where the compartment boundary was
- the door between the designated centre and the adjoining residence did not provide an effective barrier to fire, to protect the designated centre from a potential fire in the adjacent area.

The arrangements for detecting fire were not adequate;

- a number of rooms and circulation areas were not fitted with smoke detection
- the dining room was fitted with heat detectors and not smoke detectors to ensure early detection of fire.

The measures in place to safely evacuate residents required action:

- the identified evacuation aid for a resident was not in close proximity to their bedroom
- the building was subdivided into areas to support progressive horizontal evacuation. Assurance was required from the provider to verify these were effective fire compartment boundaries to ensure the protection of residents during evacuation
- only a select number of staff had training in the use of the evacaution chairs. Training was required that all staff have meaningful training in the use of all evacuation aids in use in the centre.

The arrangements for giving warning of fire required action:

- the main fire alarm panel was located at first floor plan with a repeater panel under the stairs in the main reception area. The system was a zoned system and would identify the zone where the fire alarm has been activated. This type of system relies on staff to search the area of the building, the zone, to locate the fire, therefore relying on floor plans to assist in locating the zone. The zones forming the fire alarm system were large and this fact may lead to delays in locating the fire. Floor plans were available at the main panel but not at the repeater panel at ground floor. The repeater panel at ground floor was concealed in an area under the stairs. Therefore it was not readily available for consulting.

The drawings on display to support evacuation were vague and did not contain sufficient information to guide the evaucation procedure.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Medicines were well managed.

- The pharmacist was responsive to staff and residents' needs.
- The general practitioners (GPs) reviewed the use of medicines on a regular basis and revised the prescriptions where possible.
- Controlled drugs in use for a number of residents were managed in line with professional guidelines according to records seen.
- Where medicines were to be crushed or had been discontinued this had been signed by the GP.
- Staff nurses undertook appropriate, relevant training.
- Audit of medicines and particularly of psychotropic (sedative type medicines) demonstrated good practice.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

There were some aspects of care planning which required improvement to ensure that all aspects of residents' needs were addressed:

- risk assessments were not always interlinked with the care plans where necessary, for example a risk assessment for aspiration or choking was not referenced in the nutrition care plan, to ensure staff were aware of the risk when updating care plans and risk assessments.

Judgment: Substantially compliant

Regulation 6: Health care

Health care was well managed in the centre:

A review of residents' medical records in the above care plans found that recommendations from residents' doctors and other health care professionals were integrated into residents' care plans. This included advice from the dietitian, the speech and language therapist (SALT) and the physiotherapist.

Pressure ulcers and other wound care was seen to be carried out in line with professional guidelines from the tissue viability nurse (TVN).

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Staff were trained in addressing the needs of residents who could display responsive behaviours (how residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

A review of a number of relevant care plans indicated that residents had behaviour support plans in place, which identified potential triggers for behaviour escalation and any actions and therapies that best supported the resident.

Restraints such as bed-rails were risk assessed and consent for their use had been recorded.

Judgment: Compliant

Regulation 8: Protection

Inspectors were satisfied with the measures in place to safeguard residents and protect them from abuse.

The registered provider facilitated staff to attend training in safeguarding of vulnerable persons and additional training was planned.

Staff spoken with were knowledgeable of how to report any allegation of abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Residents told inspectors they were happy in the centre and felt their rights were respected and promoted.

Residents said they felt safe and had access to social outings, appropriate activity, garden activity, religious services, external and internal celebrations with family.

Residents felt that they could raise concerns about the centre and they told the inspector that their opinion would be listened to.

Activities were meaningful to them and they praised the accommodation, the staff and the support provided. Residents were seen going out to the local shopping centre, to the nearby cafe, accompanied out to eye appointments and on garden walks on the day of inspection. There was a great air of camaraderie heard between residents, relatives and staff.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Registration Regulation 8: Annual fee payable by the registered provider of a designated centre for older people	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 13: End of life	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for St Paul's Nursing Home OSV-0000433

Inspection ID: MON-0039764

Date of inspection: 14/04/2023

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 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Storage of all records have been reviewed and the following completed: 1. Archive room has been moved to a designated room for records on the first floor. This room is fully shelved and all records are stored in boxes fit for purpose. The room is locked with controlled access confined to designated personnel. 2. All resident information is now stored in lockable filing cabinets. 3. Residents' files in staff offices are secured in filing cabinets that are locked. 4. Financial details are stored in a locked cabinet in a dedicated office that is for the use of the account's person only. 5. The link corridor will be registered as part of the centre. 6. New policy is in place which covers Data Protection and Records Management and this is being rolled out to all staff members. 90% of employees have completed on line data protection legislation training as of the 29/5/2023. 7. An audit of staff files is scheduled and this will include auditing gaps in the employment details of staff members. Where gaps are identified, an explanation will be sought to ensure compliance.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. A number of fire non-compliances were identified during the inspection under Regulation 28 Fire Precautions. The provider's response and planned actions are set out in the response made under Regulation 28 below. 2. The non-compliances with regard to Records Management and the provider's response	

and planned actions are set out under Regulation 21 above.
3. Risk assessments are being carried out and kept under review. Where risks are identified they will be referenced into the relevant care plan domains to ensure staff are aware of the risk when updating care plans and to ensure safe delivery of care. The importance of ensuring risk assessments are cross referenced to the care plan domains will be reinforced to staff at communication handovers and any planned care plan training.
4. The provider has been engaged in upgrading the premises for some time. Flooring has been replaced in a number of areas, sinks and sink units have been replaced, painting has been renewed and shower rooms have been installed. This programme is scheduled to continue and earmarked for completion for end of December 2023.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
1. The sluice room is included in the daily cleaning schedules to ensure is it maintained in a hygienic condition with duties allocated to designated individual(s) The sluices have been deep cleaned and the bedpan washers are scheduled for servicing biannually.
2. An ongoing refurbishment plan is in place and scheduled to continue with the ongoing replacement of vanity units, sinks and bedroom furniture as identified.
3. The cleaning schedules will be reviewed to ensure all areas of the centre are on a cleaning schedule. Supervision of cleaning being carried out is to be intensified. Audit tools will be reviewed to ensure they are sufficiently robust to pick up and identify all areas that require cleaning.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Precautions against the risk of fire:
• Separate external designated smoking areas for residents and residents are earmarked for installation. Both areas will be provided with appropriate firefighting equipment to include fire blankets (1.8m X 1.8m) in a weather proof cabinet. The designated resident smoking area will provide for suitable seating, fire retardant apron(s), emergency call alert and metal receptacle for disposal of cigarettes. The target completion date is end of July 2023. The fire policy will be updated to reflect these designated areas and will be communicated to all staff via briefings and fire safety training sessions. The statement of purpose and residents guide will also be updated to reflect these arrangements.
• Storage arrangements external to the centre have been reviewed. The area has been

decluttered and the fire load has been reduced. Additional smoke sensors have been installed. The wall between the chemical store and the basement is earmarked to be upgraded to give a one-hour fire rating in addition to putting appropriate fire stopping in place where services penetrate walls or ceilings. The target date for completion of these works in the end of July 2023.
• An audit of fire doors is being undertaken. Hold open mechanisms linked to the fire detection alarm system (FDAS) are scheduled to be installed on a phased basis commencing with the high risk areas following risk assessment. All persons will be informed that the practice of wedging or propping doors open should cease.
• The archived files in the room housing electrical panels have been removed to a dedicated archive room.
• The area under the stairs is planned to be provided with a one-hour fire rating to include the door. Smoke detection coverage will also be provided. These works are scheduled for completion by mid-August 2023.
• Additional permanent electrical sockets are being provided in the nurse's station to eliminate the use of extension leads. Smoke detection coverage will also be provided.
• Arrangements are being put in place to carry out a periodic electrical inspection on the electrical installation. The completed date for these works is subject to availability of registered electrical contractor with a target date of end of November 2023.

Arrangements for providing adequate means of escape including emergency lighting:
• The key for the exit from the chapel has been addressed by the addition of a break glass unit housing the key which is sited adjacent to the exit door on the inside. The exit will be included in the daily checks of all escape routes and exits that it is free from obstruction and that keys are in situ.
• The ground floor corridor will be assessed for the purposing of subdividing the fire compartment on this floor level.
• The emergency lighting throughout the centre, both internally and externally is in the process of being upgraded and will be supported with a certificate of commissioning. The target date for completion is the end of July 2023.

Arrangements for containing fire:
• A fire rated door has been installed between the laundry and lobby. The doors between the dining room and kitchen have been adjusted and now close correctly. The hole between the kitchen and laundry room where the gas pipe penetrated has been sealed up with appropriate fire stopping material.
• An audit of fire doors is being undertaken for the purposes of identifying remedial works for completion to ensure compliance. These works where identified will commence with the high risk areas on a phased basis. The target date for completion is December 2023.
• An assessment of service and other penetrations, gaps or holes will be carried out and a fire stopping programme put in place with a target completion date of December 2023.
• The compartment boundary between the chapel and 1st floor will be assessed and when determined and if required, suitable fire rating will be put in place with a target completion date of the end of August 2023.
• The door between the designated centre and adjoining residence will be upgraded to provide an effective fire barrier to fire with a target completion date of end of August 2023.

The arrangements for detecting fire:
• Additional fire detection linked to the FDAS has been put in place in areas where there were deficits in coverage and to replace the domestic style sensors installed at the time of the inspection. A commissioning certificate is available to support these additions to the FDAS. The dining room sensors have been changed out to smoke sensors.

Measures for evacuating residents:
• A review of evacuation aids being used by the centre as prescribed in the resident PEEPs will be carried out to ensure they are appropriate, available in sufficient numbers and sited in the correct location for their identified use. The identified evacuation aid referred to by the inspector in their report has now been relocated in close proximity to their bedroom.
• The building is divided into a number of fire compartments for the purposes of deploying progressive or phased evacuation. A phased evacuation strategy will typically be the only realistic evacuation strategy due to the difficulty in moving residents and potentially extended evacuation times. This is usually through movement horizontally through the building in the initial stages and followed by vertical movement if more than single storey. The fire compartments will be reviewed by a competent person to ensure they are effective compartment boundaries with a target date of completion by the end of July 2023 excluding any remedial works which may be prescribed.
• The fire safety training programme will be reviewed to include training on all evacuation aids including the use of evacuation chairs. The use of such aids will be reflected on the centre fire policy/fire emergency action plans and reinforced by their use at practiced fire drills. The target completion date is end of August 2023.

Arrangements for giving warning of fire:
• The FDAS fire zone drawings will be reviewed to ensure they are of sufficient size and detail to assist staff in an activation. Fire floor plans in accordance with the fire codes will also be reviewed to provide the necessary detail. Zone drawings and fire floor plans will be sited at each fire panel location. Access to the ground floor repeater panel will be kept free from obstruction. The target date for completion is the end of July 2023.

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:
Risk assessments are being carried out and kept under review. Where risks are identified they will be referenced into the relevant care plan domains to ensure staff are aware of the risk when updating care plans and to ensure safe delivery of care. The importance of ensuring risk assessments are cross referenced to the care plan domains will be reinforced to staff at communication handovers and any planned care plan training.

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 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	31/07/2023
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	31/07/2023
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	31/07/2023
Regulation 27	The registered	Substantially	Yellow	31/12/2023

	provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Compliant		
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	30/11/2023
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/07/2023
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	31/12/2023
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre	Not Compliant	Orange	31/08/2023

	to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/08/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/08/2023
Regulation 28(2)(ii)	The registered provider shall make adequate	Not Compliant	Orange	31/08/2023

	arrangements for giving warning of fires.			
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	Orange	31/08/2023
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	31/07/2023
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	31/07/2023