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: | AbbeyBreaffy Nursing Home |
| Name of provider: | Knegare Nursing Home Holdings Ltd |
| Address of centre: | Dublin Road (N5), Castlebar, Mayo |
| Type of inspection: | Announced |
| Date of inspection: | 21 February 2025 |
| Centre ID: | OSV-0000308 |
| Fieldwork ID: | MON-0038825 |

## About the designated centre

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

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

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

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

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| Number of residents on the date of inspection: | 54 |

## 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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| Friday 21 February 2025 | 09:20hrs to 16:50hrs | Michael Dunne | Lead |
| Friday 21 February 2025 | 08:00hrs to 15:30hrs | Gordon Ellis | Support |

## What residents told us and what inspectors observed

On the day of inspection, the inspectors observed that residents were supported to enjoy a satisfactory quality of life supported by a team of staff who were kind, caring and responsive to their needs. The overall feedback from residents was that they were happy with the care they received and that staff looked after them very well, one of the residents' who expressed a view told the inspectors that this was a ''great spot''.

The inspectors also reviewed a number of resident questionnaires received during the inspection which had been completed by residents and in some cases by their relatives or staff. These questionnaires focused on residents' experiences living in the designated centre in relation to care, environment, activities, staff, meals and their overall comfort. All of the responses reviewed were positive, with a focus on the kindness of staff working in the centre as the following comments demonstrate; '' communication is very good with family members'' and that their loved one feels that this centre is ''their home''.

Following an introductory meeting with the provider, the inspectors commenced unaccompanied walks about of the designated centre. The centre was clean, warm and odour free. The inspectors observed a number of bedrooms undergoing a deep clean. There were alcohol hand rub dispensers located in key areas throughout the centre which were found to be well-maintained. Flooring surfaces were clean and well-maintained and there were handrails along all of the corridors to support residents as they mobilised around the centre.

There was signage available throughout the centre to guide residents, staff and visitors to key locations such as dining, visiting and day rooms. There was also a range of information on display in relation to fire safety which included actions to take in the event of a fire emergency. The provider also maintained a number of information booklets for residents and visitors which included information on restrictive practice, safeguarding,advocacy and trips, slips and falls.

Accommodation is provided mainly in single-occupancy bedroom accommodation with a number of these rooms serviced by an ensuite facility which includes a wash hand basin, toilet, and shower area. There are also four twin-occupancy bedrooms available in this centre. The layout of one twin-occupancy room bedroom 55 was not suitable for two residents sharing and, these findings are discussed under Regulations 17 and 9. At the time of this inspection bedroom 55 was being used for single occupancy with one resident residing in the room. There were 52 residents living in the centre on the day of the inspection.

Residents who spoke with the inspectors expressed satisfaction with the care and attention provided by the staff team which was validated by the information reviewed in the residents' questionnaires. Resident's told the inspectors that staff were very helpful and dedicated to their roles. Those residents who met the

inspector confirmed that they felt safe living in the centre and that they could discuss any concerns they had with any member of the team. A number of staff and residents interactions were observed, residents who presented with communication needs were supported by staff in a positive manner. Resident's were given time and space to make their views known. These interactions confirmed that staff were aware of resident's assessed needs and were able to respond to those needs in a positive manner. Residents who walked with purpose were supported by staff in a dignified manner and this approach was seen to reduce potentially challenging situations and maintain the safety of those residents.

During the walk about the inspectors observed residents were either engaging in group activities or following their own individual daily routines. There was a varied activity schedule in place which covered the entire week. Several residents participated in the ball toss game while others were supported to engage with the arts and crafts session. Other activities scheduled for the day of the inspection included a music session and a bingo activity. Communal rooms were well set up to provide activities for the resident's, with sufficient equipment in place to provide music and arts & crafts activities. Residents were observed attending the hairdresser which residents mentioned they looked forward to every Friday. Most communal areas displayed pictures of residents engaged in either group or individual activity. At the time of this inspection staff organised a puppy to visit the centre. Observations confirmed that residents participated eagerly and thoroughly enjoyed this visit.

Residents told inspectors that they enjoyed the food provided for them. The dining room was well-presented with sufficient tables and chairs to cater for the number of residents attending the meal service. Tables were dressed with tablecloths, cutlery and condiments. Menu's were provided both in pictorial format and in written format. The menu on the day of the inspection consisted of an option for seafood pie or glazed bacon. Residents told the inspectors if they did not like the choice of food available then they could request an alternative meal.

The next two sections of this report present the findings of this inspection in relation to the governance and management of the centre and how these arrangements impacted on the quality and safety of the service provided to residents.

## Capacity and capability

This inspection found that the centre was well managed by an experienced team who promoted an open and, inclusive culture in which residents received person centred care, in line with their needs and preferences. The registered provider was found to have completed several actions to address the non-compliance identified on previous inspections.

This was an announced inspection to monitor the registered provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for

Older People) Regulations 2013 (as amended) and to follow up on actions the provider had agreed to implement as a result of the findings of an inspection carried out in August 2024.

Findings on this inspection confirmed that care and services were delivered in accordance with the statement of purpose. There was a clearly defined management structure which provides effective oversight of the designated centre. Staff were clear about their roles and the standards that are expected of them in their work. Reporting and communication structures were well established and staff worked well together as a team.

The designated centre is operated by Knegare Nursing Home Holdings limited and is the registered provider for AbbeyBreaffy Nursing Home. The person in charge is supported by an assistant director of nursing (ADON) a clinical nurse manager (CNM), staff nurses, health care assistants, activity staff, household, and maintenance personnel.

There were comprehensive quality assurance systems in place to ensure care and services were safe and appropriate. The audits and management reports were reviewed and monitored by the senior management team. Where non-compliance or improvements were identified an improvements action plan was implemented. The management team and staff were open to feedback and demonstrated a commitment to continuous improvement. Overall the audit processes were found to be effective however, the oversight of records relating to residents communication needs had not identified some of the findings of this inspection. These findings are set out under Regulation: 23.

There were sufficient numbers of staff available in the designated centre on the day of the inspection to meet the assessed needs of the residents. Arrangements were in place to maintain staffing levels to cover staff absences. A review of the rosters confirmed that all absences had been filled.

There was a comprehensive training programme in place which incorporated a selection of both face to face and online training. Records confirmed that all staff were up to date with their mandatory training in safeguarding, fire safety and manual handling. Supplementary training included modules on infection prevention and control, training in medication management, wound management, dysphagia, human rights, the prevention of pressure ulcers and training on the use of restrictive practices.

A review of records relating to accidents and incidents confirmed that these were well-managed in line with the provider's policies and procedures. The provider submitted the required notifications to the Chief Inspector in line with Schedule 3 of the regulations.

There was a complaints procedure in place which was made available for residents and their representatives. Details of the complaints procedure were available on the resident's information board. The procedure had been updated since the last inspection and was now in line with the regulations. The policy included information about patient advocacy services. The provider had not received any formal

complaints since the last inspection. A small number of informal complaints were recorded and managed by the nursing and care team where possible. Complaints were discussed at team meetings and staff were made aware of any improvements that were required in their areas.

The annual review for 2024 and quality improvement plan for 2025 included feedback from residents and staff. The majority of improvement actions were implemented at the time of the inspection.

## Regulation 15: Staffing

There were adequate numbers of staff with appropriate skills available to meet residents' assessed care and support needs. Staff were knowledgeable regarding residents' individual needs and assisted residents with meeting their needs without delay.

Judgment: Compliant

## Regulation 16: Training and staff development

Staff had access to appropriate training for their roles. Mandatory training was provided in key areas such as adult safeguarding, moving and handling and fire safety. Refresher training was available to ensure staff maintained their training requirements. As a result staff demonstrated appropriate knowledge and skills in their work.

Training records reviewed by the inspectors in the centre confirmed that staff had completed a selection of online and in-house training activities. Staff who had recently joined the company were in the process of completing their induction and had already completed their mandatory training requirements.

Judgment: Compliant

## Regulation 23: Governance and management

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

- Not all audits were identifying areas that required improvement and as such, action plans to address these areas were not created to improve the quality of the service. This is discussed further under Regulation 10.

In addition to this, the provider had not provided the required resources to complete all required fire safety works within the specified date committed to by the provider following the previous inspection in August 2024.

Judgment: Substantially compliant

## Regulation 3: Statement of purpose

The statement of purpose contained the information as set out in Schedule 1 of the regulations. The statement of purpose had been reviewed on 20 February 2024.

Judgment: Compliant

## Regulation 31: Notification of incidents

Incidents set out in Schedule 4 of the regulations were notified to the Chief Inspector within three working days. The person in charge submitted the quarterly notification reports to the chief inspector as required.

Judgment: Compliant

## Regulation 34: Complaints procedure

There was a complaints policy in place and this was updated in line with regulatory requirements. Records of complaints were maintained in the centre and the inspectors observed that these were acknowledged and investigated promptly and documented whether or not the complainant was satisfied.

Judgment: Compliant

## Quality and safety

Residents living in this centre experienced a good quality of life and received timely support from a caring staff team. Residents' health and social care needs were met through well-established access to health care services and a planned programme of social care interventions. Overall,the centre was well managed which ensured continuing improvements in the compliance findings on this inspection. The provider had completed several actions from the previous inspection in 2024.

The provider had carried out significant fire safety improvement works across the centre. Compartmentation cross corridor doors had been fitted to reduce the size of existing compartment areas, fire stopping had been completed in the attic areas, works to external evacuation paths and emergency lighting had been carried out, internal emergency directional signage had been fitted throughout and remedial works to a number of fire door sets was in progress. These works were all in order to improve the fire safety measures throughout the centre.

In addition the provider had provided ongoing staff training in fire safety and fire evacuation drills and staff were knowledgeable about the resident's support needs in the event of a fire emergency in the centre.

Notwithstanding this, some works were overdue at the time of the inspection and time lines for other works had been extended with no confirmed date for completion. This was evident from a review of the providers own fire safety risk assessment dated May 2024 and their time bound action plan committed subsequent to a previous inspection in August 2024.

These outstanding fire risks were in regards to; extending the compartment walls into the attic space that enclosed the kitchen, the installation of fire rated attic hatches and the completion of remedial works to upgrade compartment walls along with service penetrations through fire rated walls of high risk areas, in particular to a boiler room.

As previously stated in this report this inspection found good progress had been made by the provider to address the fire risks in the centre since the previous inspection. Notwithstanding this, the continued delay in addressing the outstanding risks had impacted on the safety of the residents. Appropriate effort and resources were now required by the provider to bring the centre into compliance with Regulation 28: Fire Precautions.

All residents had an assessment of their needs on admission to the designated centre to ensure that the designated centre was able to meet their needs for care and support. Following the assessment care plans were developed with the resident or their representative setting out care needs and the residents preferences for care and support. Care plans also identified resident's self-care abilities to ensure that residents independence was promoted. Improvements were still required in relation to the way that care plans were written and updated for residents with a communication need. This is a repeated finding from the last inspection.

Residents had good access to their general practitioner (GP) and specialist medical services including psychiatry of old age. Specialist health services such as dietitian, speech and language therapy, tissue viability nurses, palliative care and occupational

therapy and physiotherapy services were made available for residents in line with their needs. A review of transfer records confirmed that the provider included key information for residents who were transferred to an acute centre.

There was an ongoing re-decoration programme in place which improved the ambiance of the designated centre and included painting and redecoration of resident bedrooms and communal areas. The flooring in the utility area had been upgraded and this area was being repainted at the time of this inspection.

The majority of resident bedrooms had also been repainted. Residents were seen to personalise their own lived environment with items individual to them. Rooms were clean and well-maintained and there was sufficient space for residents to store their clothes and personal items. Some bedrooms had also had their flooring replaced. The layout of one twin-occupancy bedroom did not comply with the regulations and is discussed further under Regulation 9: Residents' rights. The provider informed inspectors that they intended to reorganise the layout of this room when it became vacant, currently there was one resident residing in this room.There is good availability of communal rooms for residents to use. These rooms were found to be tastefully decorated and suitable for their intended purpose. Residents had unrestricted access to a large garden area which was secure and contained sufficient seating for residents to use when visiting this area.

Overall residents rights were upheld and residents were supported to remain independent and lead their lives as they wished to in the centre. There was a seven day activity schedule advertised in key locations so that residents would be aware of what was on. The inspectors observed staff attending to residents who spent most of their day in their bedrooms which ensured that residents had some quality social time with staff outside of care interventions. There was good attendance at the activities sessions on the day.

Residents had access to newspapers, radio and television. Internet access was also available so that residents could keep in touch with family and friends through social media. Resident meetings were held every month and the the agenda covered key areas of the services such as food and catering, management update, activities, resident feedback, and resident care issues. Residents had access to advocacy services when required. The provider made available a residents guide which provided key information about the centre for the residents.

Residents reported high levels of satisfaction with their meals and other refreshments. The inspectors observed a lunch time meal service and found that there were sufficient staff available to support residents at meal times.

## Regulation 10: Communication difficulties

The interventions to support a resident where English is not their first language were non specific and as such would be ineffective in meeting the assessed needs of this resident as it did not accurately identify the resident's first language and their

requirements for support with translation needs. Therefore, it was unclear as to how the resident's communication care plan would support this resident to communicate effectively.

Judgment: Substantially compliant

## Regulation 13: End of life

A sample of care plans reviewed confirmed that residents and or their family members were consulted in relation to creating a care plan that was consistent with the residents end of life wishes. Treatment and care preferences were clearly documented in the care plans reviewed.

There was access to palliative care services to support residents who were at end of life. Records relating to the resident's wishes for medical interventions at end of life or in a medical emergency were recorded and made available to staff. These instructions were reviewed on a regular basis.

Judgment: Compliant

## Regulation 17: Premises

The centre was found to be clean, clutter free and maintained to a good standard. There was an ongoing decoration programme in place which included painting, redecoration and upgrading of flooring.

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

The layout of a twin-occupancy bedroom had not changed since the previous inspections. This room was occupied by one resident on the day of the inspection.

- The layout of the room meant that when the resident in the first bed was accessing the en suite facility they would need to enter the second resident's bedspace.
- All of the wardrobes storage facilities in the bedroom, were located in the bed space of the resident occupying bed 1. This meant that the resident in the second bed did not have access to their wardrobe without entering the first resident's private space.
- There was insufficient space available for a comfortable chair to be located beside the 2nd bed space as this would inhibit access to the en-suite facilities by the resident in the 1st bedspace.

Maintenance was required to some newly fitted cross corridor fire doors due to gaps found between the double doors. There were a number of areas where wall and ceiling surfaces required sealing and redecoration to address gaps in these surfaces.

Judgment: Substantially compliant

## Regulation 20: Information for residents

The resident information guide that was made available for residents and their families and contained all of the information required under Regulation 20. The following information was included in the guide:

- A summary of the services provided in the designated centre.
- The terms and conditions relating to residence in the designated centre, a minor amendment was required to ensure accuracy regarding the fees for service charges.
- The complaints procedure.
- The visiting arrangements that were in place for residents to receive their families and friends.
- The arrangements in place to access independent advocacy services.

Judgment: Compliant

## Regulation 25: Temporary absence or discharge of residents

A copy of transfer letters for times when a resident was transferred to another care facility for treatment were maintained on site. These documents contained comprehensive information to enable the resident to be cared for in accordance with their current needs. There were arrangements in place for safe discharge of residents which included discharge planning, the sharing of relevant information and effective communication with families, social workers, and general practitioners, (GPs).

Judgment: Compliant

## Regulation 26: Risk management

There was a risk management policy which met the requirements of the regulations. Overall risks were well-managed in this centre, in instances where hazards were identified, appropriate controls were put in place to either remove or reduce the

identified risk. A review of incidents and accidents was carried out by the provider in an attempt to identify learning opportunities to improve the service to the residents.

Judgment: Compliant

## Regulation 28: Fire precautions

The provider was working through a programme of fire safety works, some of which had been completed at the time of this inspection and some that were due to be completed at a later date. Notwithstanding this, due to the lack of progress in some areas and the findings of this inspection, the registered provider was failing to meet the regulatory requirements on fire precautions in the centre and had not ensured that residents were adequately protected from the risk of fire. Improvements were required in the following areas:

The provider needed to improve adequate means of escape including emergency lighting. For example:

The inspectors observed additional emergency lighting had been installed to the exterior of the designated centre. Notwithstanding this, the inspectors noted a number of locations recommended in the providers own Fire Safety Risk Assessment (FSRA) had not been installed at the side and rear of the designated centre. This required a review.

A gate from an enclosed courtyard was noted to be fitted with keypad access control. The providers own fire safety risk assessment (FSRA) recommended the gate to be fitted with access control function and directly linked to the fire detection alarm system. However,this recommendation had not been carried out at the time of the inspection.

In addition to this, a staff member when asked to open the gate, did not know the code to open the gate and had to ask another staff member where the code was kept. Furthermore, a slide bolt was noted to be fitted on the opposite side of the gate. This was brought to the attention of a staff member who removed the slide bolt immediately.

This created a risk of residents who could potentially be evacuated into the enclosed courtyard being able to open a fire exit out of the enclosed garden in the event of a fire or their evacuation being delayed.

The provider needed to improve adequate arrangements for maintaining the means of escape, building fabric and the building services. For example:

Some of the newly fitted compartment boundary fire doors did not close fully when released by the inspectors and had gaps over the allowable tolerance between the vertical stiles.

While it is acknowledged the provider`s programme of works to address a number of deficiencies to fire doors throughout the centre is due to be completed by April 2025, the inspectors noted a number of bedroom doors, while recorded were still missing smoke seals. This required a review to ensure the required fire safety works to all fire doors were completed in full.

Some ceiling areas had been fitted with plastic covers to seal off holes. This would not provide the required fire rating for a sealing and required a review.

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

At the time of this inspection, the provider had made progress in carrying out the required fire safety works as outlined in their FSRA dated May 2024. However, the provider had not fulfilled previously committed to timelines for addressing these fire risks in respect of; extending the compartment walls into the attic space that enclosed the kitchen, the installation of fire rated attic hatches and the completion of remedial works to upgrade compartment walls along with service penetrations through fire rated walls of high risk areas, in particular a boiler room.

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

From a review of the providers FSRA and committed to timelines for addressing fire risks in the designated centre, the inspectors noted that scheduled works to the kitchen that consisted of; extending the compartment walls into the attic space to address the compartment deficiencies had not started. A timeline for when these works would be addressed could not be provided by the staff on the day of the inspection. The lack of progress in addressing this risk prolonged even further the on-going fire risk and safety to residents of a potential fire being able to spread from this high risk room.

In a boiler room located within the designated centre, the inspectors observed several penetrations through a ceiling that require fire sealing. Furthermore, a small section of the internal wall that enclosed the room was not intact. The providers FSRA report outlined that compartment walls to this room were required to be upgraded. In addition to this, the FSRA report stated that service penetrations through fire rated walls of high risk areas, which this room is, were to be fire stopped. This was brought to the attention of staff on the day who agreed that fire safety works to this high risk room should be prioritised as part of the on-going fire safety works throughout the centre.

The displayed procedures to be followed in the event of a fire required a review by the provider. The fire evacuation plans displayed throughout the centre were not accurate, were inconsistent and required more detail. For example:

There was a mixture of old floor plans and new floor plans that indicated the new fire safety works that had taken place. Doors that had been removed due to fire safety works were still indicated on some floor plans. Some floor plans lacked detail as there was no indication fire compartments, fire escape routes, fire extinguishers

or call points. This was a repeated finding from a previous inspection. Furthermore, there was a lack of a fire zone floor plan displayed at the main fire panel. This created a risk of causing confusion and delaying evacuation procedures in the event of a fire.

Judgment: Not compliant

## Regulation 5: Individual assessment and care plan

Care plans were developed following an assessment of residents needs, and were reviewed at four month intervals in consultation with the residents and, where appropriate, their relatives. The care plans reviewed were person-centred, and reflected residents' needs and the interventions in place to manage identified risks such as those associated with impaired skin integrity, risk of falls and risk of malnutrition. There was sufficient information to guide the staff in the provision of health and social care to residents based on residents individual needs and preferences.

However, care plans to assist residents with their communication needs did not contain sufficient information to ensure that effective interventions were implemented to ensure best outcomes for residents. This is discussed further under Regulation 10: Communication difficulties.

Judgment: Compliant

## Regulation 6: Health care

A review of the residents' medical notes found that recommendations from the residents' doctors and allied health care professionals were integrated into the residents' care plans. There was evidence to indicate effective management of residents' healthcare which resulted in positive clinical outcomes for residents living in the designated centre.

Judgment: Compliant

## Regulation 7: Managing behaviour that is challenging

There was evidence to confirm that residents who presented with responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical

environment), were cared for in a positive and individualised manner. Where restrictive measures were introduced they were done so as the least restrictive option. For example, a resident who currently had bed rails in place was initially trialled on a low entry bed to maximise their independence. The inspectors found that there was effective monitoring and record-keeping of restrictive practices in the designated centre.

Judgment: Compliant

## Regulation 9: Residents' rights

The layout of a twin-occupancy bedroom, bedroom 55, had not changed since the last inspection and did not ensure that each resident's rights to privacy and dignity would be upheld. This room was occupied by one resident on the day of the inspection.

- All of the wardrobes storage facilities in the bedroom, were located in the bed space of the resident occupying bed 1. This meant that the resident in the second bed would need to enter the first resident's private space to access their wardrobe.
- The layout of the room meant that when the resident in the first bed was accessing the en suite facility they would need to enter the second resident's bedspace.
- The privacy curtain rail around the second bed did not provide enough room inside the curtain for this resident to carry out personal activities in private especially if they needed to use assistive equipment such as a hoist or comfort chair.

Judgment: Substantially compliant

## Appendix 1 - Full list of regulations considered under each dimension

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

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 23: Governance and management | Substantially compliant |
| Regulation 3: Statement of purpose | Compliant |
| Regulation 31: Notification of incidents | Compliant |
| Regulation 34: Complaints procedure | Compliant |
| **Quality and safety** | |
| Regulation 10: Communication difficulties | Substantially compliant |
| Regulation 13: End of life | Compliant |
| Regulation 17: Premises | Substantially compliant |
| Regulation 20: Information for residents | Compliant |
| Regulation 25: Temporary absence or discharge of residents | Compliant |
| Regulation 26: Risk management | Compliant |
| Regulation 28: Fire precautions | Not compliant |
| Regulation 5: Individual assessment and care plan | Compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Managing behaviour that is challenging | Compliant |
| Regulation 9: Residents' rights | Substantially compliant |

# Compliance Plan for AbbeyBreaffy Nursing Home OSV-0000308

## Inspection ID: MON-0038825

## Date of inspection: 21/02/2025

**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 | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>• A full review of current audit systems has been completed. All audits will now include clear criteria to identify areas for improvement. Where issues are identified, time-bound action plans will be created and assigned to responsible staff. Implementation and progress will be reviewed during monthly management meetings. Completed and ongoing.<br>• Outstanding fire safety works have been reviewed by the Support Services Manager. Resources have now been allocated to ensure completion of all outstanding items. A revised and realistic timeline for these works has been agreed upon and communicated to all relevant stakeholders. The Senior Management Team is closely monitoring progress to ensure timely completion and to prevent any further delays. Ongoing.<br>• The QIP will be updated annually to reflect audit results, fire safety progress, and service improvement areas. Ongoing. | |
| Regulation 10: Communication difficulties | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 10: Communication difficulties:<br>• The resident's care records have been reviewed and updated to accurately reflect their first language. Language preferences and relevant cultural considerations have been clearly documented within the resident's communication assessment. Completed.<br>• A revised, person-centred communication care plan has been developed. This outlines the specific methods, tools, and supports required to facilitate effective communication. | |

Supports now include, where necessary, the use of visual aids, interpreter services, translation applications, and clear staff guidance on simple, culturally sensitive communication techniques. Completed.
• All relevant staff have received refresher training on supporting residents with communication difficulties, with particular emphasis on meeting the needs of those for whom English is not their first language. Completed and Ongoing.
• Staff have been instructed to reference and adhere to each resident's individualised communication care plan during daily care routines. Completed and ongoing.
• The effectiveness of the communication care plan will be monitored regularly and reviewed as needed. Completed and Ongoing.
• Prompt adjustments will be made to the care plan if communication challenges persist or if the resident's needs change over time. Completed and Ongoing

| Regulation 17: Premises | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 17: Premises:
• Twin-Occupancy Bedroom Layout: The twin room identified is currently occupied by one resident only and has been maintained as single occupancy for the past five years. To uphold resident dignity and privacy, the room will remain single occupancy for the duration of the current resident's stay, in line with their preference. A full redesign of the room layout will be considered once the room becomes vacant. This will include relocation of wardrobes, reconfiguration of en-suite access, and provision for sufficient space for furniture, ensuring suitability for potential future dual occupancy.

• Fire Door Maintenance: The gaps identified between newly fitted cross-corridor fire doors have been reviewed by the maintenance and support service manager. A contractor has been engaged to carry out the necessary adjustments to ensure the fire doors meet regulatory standards. All adjustments will be completed by 30th June 2025, with follow-up inspections by the Fire Safety Officer to verify compliance.

• Surface Repairs and Redecoration: Areas with visible gaps on walls and ceilings have been scheduled for sealing, repair, and redecoration as part of our ongoing premises improvement programme. These works are expected to be completed by 31st May 2025, ensuring all affected areas are restored to a safe and appropriate standard.

• The existing redecoration and refurbishment programme remains active, ensuring flooring, paintwork, and fittings are reviewed and updated routinely. A maintenance tracker is in place to ensure prompt resolution of all environmental issues and continuous compliance with Regulation 17.

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| Regulation 28: Fire precautions | Not Compliant |

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• A full review of the Fire Safety Risk Assessment (FSRA) has been completed by the Support Services Manager, with particular focus on outstanding external emergency lighting requirements. A lux level test around the waste compound has been carried out on the 16/04/2024. Following the review an additional 7 emergency lights will be installed around from the garden gate towards the laundry room. Due for completion 31/05/25.
• The courtyard gate will be fitted with a release mechanism linked to the fire alarm system by 31/05/25.
• In the interim, access codes for emergency exits have been discussed with staff. All staff received updated guidance and training to ensure prompt evacuation during an emergency. Completed.
• All newly installed fire doors will be re-inspected and adjusted to meet fire resistance standards and close fully when released. Smoke seals will be fitted to all relevant bedroom doors. All plastic ceiling covers used to seal holes will be replaced with fire-rated materials to maintain appropriate fire resistance. These actions will be completed by 30th June 2025.
• As part of ongoing fire safety improvements, the kitchen compartment walls are scheduled to be extended into the attic space, with works approved and a completion date set for 31 July. Although the kitchen is located in the service corridor, separate from the main residential living areas, the potential fire risk has been communicated to all relevant staff. In the interim:
o Fire doors in this area are to be kept closed at all times.
o Smoke detection is operational within the attic space to provide early warning in the event of a fire.
o All staff are frequently involved in completing fire simulation drills.
• Work has commenced on the Fire-rated attic hatches. The remaining 3 attic hatches will be completed by 15th May 2025.
• All compartment upgrades in identified high-risk areas will be verified by a qualified fire safety professional upon completion.
• The plant room (boiler room) has been fire rated with installing a new ceiling with fire rated plasterboard and closing all service penetrations. This was completed on 14/03/25.
• All fire evacuation floor plans throughout the centre will be updated to reflect Fire compartments, Escape routes, Fire extinguishers, Call points. A detailed fire zone map will be displayed at the main fire panel. Outdated floor plans will be removed, and new signage will be installed by 30th May 2025.
• The Support Services Manager will oversee all fire safety works and ensure ongoing compliance with Regulation 28. Monthly monitoring of the fire safety action plan will be conducted, and progress will be audited monthly by the Support Services Manager, with updates shared with the Registered Provider.

| Regulation 9: Residents' rights | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Bedroom 55, originally intended for twin occupancy, has been occupied by a single resident for the past five years and will continue to remain single occupancy. There are no plans to admit a second resident into this room. This arrangement is in place to ensure the current resident's privacy and dignity are fully respected, in accordance with Regulation 9.
• The room will remain single occupancy for the duration of the current resident’s stay. Once the room becomes vacant, a full review and reconfiguration will be undertaken to address any outstanding layout concerns and ensure full compliance with regulatory standards for any potential future use.

## 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 |
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| Regulation 10(2) | The person in charge shall ensure that where a resident has specialist communication requirements, such requirements are recorded in the resident's care plan prepared under Regulation 5. | Substantially Compliant | Yellow | 15/03/2025 |
| Regulation 17(2) | The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6. | Substantially Compliant | Yellow | 30/06/2025 |
| Regulation 23(a) | The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery | Substantially Compliant | Yellow | 30/05/2025 |

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| | of care in accordance with the statement of purpose. | | | |
| Regulation 23(c) | The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. | Substantially Compliant | Yellow | 30/05/2025 |
| Regulation 28(1)(b) | The registered provider shall provide adequate means of escape, including emergency lighting. | Substantially Compliant | Yellow | 31/05/2025 |
| 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 | 31/07/2025 |
| Regulation 28(1)(c)(ii) | The registered provider shall make adequate arrangements for reviewing fire precautions. | Not Compliant | Orange | 31/05/2025 |
| Regulation 28(2)(i) | The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. | Not Compliant | Orange | 31/07/2025 |
| Regulation 28(3) | The person in charge shall ensure that the procedures to be | Substantially Compliant | Yellow | 30/05/2025 |

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| | followed in the event of fire are displayed in a prominent place in the designated centre. | | | |
| Regulation 9(3)(b) | A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private. | Substantially Compliant | Yellow | 21/12/2025 |