Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Aperee Living Bantry
Name of provider:	Aperee Living Bantry Ltd
Address of centre:	Seafield, Bantry, Cork
Type of inspection:	Unannounced
Date of inspection:	18 November 2022
Centre ID:	OSV-0004452
Fieldwork ID:	MON-0038437

About the designated centre

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

Aperee Living Bantry is a single storey facility located approximately two kilometres from the town of Bantry. The centre offers long-term, respite and convalescence care to persons that are predominantly over the age of 65 years requiring 24-hour nursing care. The centre can accommodate 50 residents in 42 single bedrooms and four twin bedrooms, all of which are en suite with shower, toilet and wash hand basin. The centre is located on large grounds with ample parking for visitors and staff. There are a number of sitting rooms for use by residents and also a quiet room for residents to spend time alone or to meet with visitors.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	45

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Friday 18 November 2022	10:30hrs to 19:00hrs	Niall Whelton	Lead

What residents told us and what inspectors observed

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

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

Aperee Living Bantry is within a two storey building, with the designated centre occupying the entire ground floor. There is small lower ground floor which is not part of the designated centre. The building is on a sloping site, located on the outskirts of Bantry town. It can accommodate 50 residents in 42 single and four twin bedrooms. All bedrooms had en suite facilities. There were 45 residents living in the centre at the time of inspection. All twin bedrooms were being used as single occupancy. Communal space consisted of a large sitting room with access to an enclosed courtyard, two dining rooms, and a sitting room with a visiting area attached. There was a covered area in the courtyard for residents who chose to smoke.

Escape routes were unobstructed and clear for use. Some external escape routes were sloped and noted to be steep and not provided with handrails.

During the walk through of the centre, deficiencies to some fire doors were noted. The inspector saw where upgrades to heat and smoke seals on fire doors was progressing.

The inspector saw that the fire doors to the bedrooms in the centre were fitted with devices which afforded the resident the choice to keep their door open and door closers were not an impediment to their movement through the building. Once the fire alarm activates, those doors would close.

The electrical rooms were noted to be free of storage. There were holes through fire rated construction which were not sealed up. There was a newly upgraded fire alarm panel with zoned floor plans adjacent.

There were pictorial prompts affixed to bedroom doors to alert staff to the mode of evacuation for the resident in the room. Some were noted to be missing from the door.

Within the laundry room, the ironing equipment was stored adjacent to the gas supply pipe. The inspector noted the dryer had its lint screen cleared and there was a completed lint removal schedule displayed to verify this.

Within the sluice room, inappropriate storage was observed including vacuum

machine, floor cleaning machine, a step ladder, empty cardboard boxes and buckets on the floor.

Externally the courtyards were well maintained and provided with nice planted areas interspersed through the paved areas. The smoking area had a fire blanket and extinguisher, but was not provided with a call bell. The inspector saw the wiring for the call bell internally, but it had not yet been connected to the smoking area.

Although not part of the designated centre, it came to the attention of the inspector that the apartments at lower ground floor were being used for storage with fire doors routinely left open. Archive files for the designated centre were also stored there. Food supplies were noted to be stored in an external building not within the registered floor area.

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

Capacity and capability

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

While the inspector found that the day-to-day governance systems within the centre were adequate, the organisational structures in place to support the centre were weak. The registered provider of this centre is Aperee living Bantry Ltd. and recent changes in this company's structure had resulted in a reduced organisational support team consisting of one director, representing the registered provider and one regional manager. The impact of these changes was evident in the lack of progress made in relation to action that had been required to address significant fire safety issues. These had been identified in a fire safety risk assessment conducted by the provider in November 2021. This assessment had identified ten extreme risks and ten high risks (requiring urgent action within three months).

There was little meaningful progress made on the identified extreme risks. A red risk relating to inappropriate storage in electrical and plant rooms had been addressed locally by the staff in the centre and the fire alarm system had been upgraded. Outstanding red risks were dependent on the registered provider to address. At the time of the inspection there was no time bound plan available to address the extreme risks. As a mitigating measure, an additional night porter was on duty;

responsibilities included a two hourly walk-through of the centre.

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

Regulation 23: Governance and management

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

- failure to date to address, and failure to have a time bound plan of action for, the fire safety risks identified in the aforementioned fire safety risk assessment
- failure to ensure effective oversight of the adequacy of the means of escape and evacuation procedures
- failure to ensure effective oversight of the fire safety checks being completed by the night porters
- failure to ensure the the implementation of all 'further controls' in the centres own risk assessment for the risk of fire

The inspector noted that food storage and archive records relating to the designated centre were stored in a non-registered areas.

Judgment: Not compliant

Quality and safety

While good practices in relation to fire safety contributed to managing the risk of fire, they did not fully mitigate the risk of fire to residents living in the centre. Upgrades to fire compartment walls, fire rated ceilings and light tunnels, inadequate fire doors, general fire sealing of gaps and holes in fire rated construction and upgrades to rear escape ramps were all yet to be completed.

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

The inspector noted that oxygen cylinders were appropriately stored in an external secure area. Fire safety training for staff was up to date. Staff spoken with were knowledgeable on the procedures to follow; however the inspector was told that the rear ramped routes had not been tested when completing fire drills. It was evident

that progress was made on works to upgrade fire doors; smoke and heat seals had been replaced on a number of doors. The inspector reviewed the smoking arrangements and found that assessments were in place for residents who smoke. Ski sheets to assist evacuation were fitted to residents' beds and those checked by the inspector were in place and fitted correctly.

The provider had implemented a system to support evacuation. This included a pictorial prompt placed on the corridor side of bedroom doors. This system was not effective and not implemented correctly, as they were not all up-to-date to correlate with residents assessed needs and some were missing.

During the inspection, it was apparent that the compartment boundaries in Mizen and Beara did not extend through the attic, with a result that these each formed a single compartment with capacity for 18 and 16 respectively; the evacuation procedure and drills practiced did not reflect this fire compartment arrangement. Furthermore, the fire safety risk assessment (dated 20 November 2021) indicated that some fire compartment boundaries in the attic did not align with corresponding compartment boundaries at ground floor.

To mitigate risks identified in the fire safety risk assessment, a night porter was in the centre at night time; duties included assisting with evacuation and completing two hourly checks of the full building. Improvements were required regarding the oversight of the night time checks, in order to ensure that fire risks would be quickly identified and to ensure the safety of residents when staffing levels were lowest.

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

Regulation 17: Premises

Action was required to ensure compliance with Regulation 17 and Schedule 6:

- The sluice room contained inappropriate storage and this posed an infection control risk
- The door to a wardrobe was hanging loose, which may cause injury to staff or the resdent
- The cord for pulling the blinds on some exit doors were not secured and may present a ligature risk
- Handrails were on one side of corridor only and not provided to some corridors
- There was no call bell available at the smoking area for residents to summon help as required

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had failed to meet the regulatory requirements in relation to fire precautions and had not ensured that residents were adequately protected from the risk of fire. The risks identified in the centre's own fire safety risk assessment, carried out in November 2021, had not been mitigated. The Inspector issued an urgent compliance plan to the registered provider for immediate action and measures for residents' safety;

- Fire compartment boundaries used for phased evacuation did not extend through the attic and did not correlate with the floor plans displayed or practiced drills

Further inadequate precautions against the risk of fire included;

- There was no documented plan to address the outstanding red risks in the centre, identified in fire safety risk assessment in November 2021.
- Not all 'further controls' in the centres own risk assessment for fire was implemented. For example, fire warden training had been proposed but not implemented and a fire door performance assessment had not been completed.
- The gas pipe in the laundry room was not adequately guarded from the risk of damage or impact. The iron was being stored adjacent, therefore may damage the gas pipe
- The emergency plan was not updated to reflect the risk of fire as per the centres own fire safety policy

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

- the rear metal ramp had varied gradients, and required a combination of manoeuvring wheelchairs backwards and forwards; this may lead to delays or injury to staff and residents during evacuation
- the two paved ramps to the rear were steep and were not provided with handrails
- the short ramps to two exits were not suitable and were located immediately outside the exit beneath the doors swing and did not have the appropriate level landing outside the door

The measures in place to contain fire were not effective. Five of the red risks identified in the fire safety risk assessment related to fire containment, not all of which were actioned;

- Notwithstanding the remedial work in progress to fire doors, there were deficits to fire doors
- The light wells to roof lights over some corridors were not adequately fire rated to protect the escape corridor. This was an identified risk in the fire

safety risk assessment

The arrangements for maintaining fire equipment were not effective:

- While there was documentary evidence to show that the emergency lighting system had quarterly servicing completed, there was no annual certificate within the last twelve months available for review.
- There were some outstanding recommendations from the periodic inspection report for the electrical installation

The arrangements for evacuating residents required improvement:

- Compartment boundaries were not known and practiced drills did not reflect potential compartment sizes
- The assessments of residents evacuation requirements did not contain sufficient information, for example, they did not include the number of staff required to assist the resident and did not align with the pictorial prompts on bedroom doors.
- The mode of evacuation had not been tried on the external ramped routes

The floor plans displayed to assist evacuation did not contain correct information regarding fire compartment boundaries.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Not compliant

Compliance Plan for Aperee Living Bantry OSV-0004452

Inspection ID: MON-0038437

Date of inspection: 18/11/2022

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The HIQA's concerns in terms of governance and management have been taken very seriously by the Registered Provider where the HIQA found that the corporate structure on the day of inspection provided a reduced organisational support team to the Director of Nursing.

Significant progress has been made by the Registered Provider to rebuild the corporate team. On 1 January 2023 a new Group CEO was appointed. He will become a Director of the company and in due course the Registered Provider Representative. Appropriate NF33As have been submitted to the Authority.

The Group Operations Manager was promoted to Chief Operating Officer on 9 January 2023. She will assume responsibility for all non-clinical corporate operations across the group and will oversee office management, marketing, IT, project management (fire, physical environment, planning, extensions, new builds), acquisition and development etc. She will report directly to the Group CEO.

The Group CEO has created a new role of Group Director of Care who will have overall responsibility for clinical care across the Group nationally and will ensure that Aperee keeps abreast of changes in legislation and practice. She will be supported in her role by two Regional Operations Managers and together they will strive to support Directors of Nursing in their roles and continue to build on the excellent work and reputation of Aperee Living. This role has recently been filled with the incumbent beginning on 27 March 2023. She will report directly to the Group CEO.

There were two vacant Regional Operations Managers positions within the group. One of

these roles has been filled with the incumbent beginning on 23 February 2023. The second role of Regional Operations Manager is currently vacant. The role has initially been advertised internally. Interviews will be held on 23 January 2023. Both positions will report to the Group Director of Care.

The Chief Operating Officer, Group Director of Care and both Regional Operations Managers will be registered with the HIQA as PPIMs and NF31s will be submitted in due course.

The Registered Provider, hereby assures the Authority of our commitment to ensuring effective compliance with all applicable rules within the Nursing Home up to and including Regulation 28: Fire Precautions.

The Registered Provider undertakes to engage fully with the HIQA and to address all fire safety related concerns in a timely manner. In this regard, on 9 January 2023, the Registered Provider, has, by separate correspondence to the Authority, provided:

(i) Evidence that a well-known Engineering firm has been appointed as Aperee's fire safety consultant and project managers for this project;

(ii) A detailed timebound Action Plan which has been developed in co-ordination with our appointed Engineer and fire safety consultant;

(iii) A copy of the Engineering firm's project plan;

(iv) Formal correspondence on behalf of our investors, committing an initial large fund to be made available in Q1 2023 for the Aperee Group to begin the agreed fireworks program.

This correspondence also confirmed that the investors are not dependent on new funding and that, as the fireworks program is developed, additional investment will be made available, if/when required.

Adequate arrangements to ensure effective oversight of the adequacy of the means of escape, fire safety checks and implementation of all further controls is detailed in Regulation 28: Fire Precautions.

Food storage and archived records stored in non-registered areas will be addressed and relocated.

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Subsequent to Inspection November 18th, all storage was removed from the sluice room.	

Routine inspections will be conducted by the Director of Nursing or other manager to ensure this area is well maintained and not used for storage going forward.

Repair works have been completed on the wardrobe door which was hanging loose.

The cord for pulling blinds on some exit doors has been secured to the wall and no longer presents as a ligature risk.

A schedule of planned maintenance works has been implemented and will include:

Extra provision of handrails on corridors.

A call bell has been installed to the designated external smoking area.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The Registered Provider, hereby assures the Authority of our commitment to ensuring effective compliance with all applicable rules within the Nursing Home up to and including Regulation 28: Fire Precautions.

The Registered Provider undertakes to engage fully with the HIQA and to address all fire safety related concerns in a timely manner. In this regard, on 9 January 2023, the Registered Provider, has, by separate correspondence to the Authority, provided:

(i) Evidence that a well-known Engineering firm has been appointed as Aperee's fire safety consultant and project managers for this project;

(ii) A detailed timebound Action Plan which has been developed in co-ordination with our appointed Engineer and fire safety consultant;

(iii) A copy of the Engineering firm's project plan;

(iv) Formal correspondence on behalf of our investors, committing an initial large fund to be made available in Q1 2023 for the Aperee Group to begin the agreed fireworks program.

This correspondence also confirmed that the investors are not dependent on new funding and that, as the fireworks program is developed, additional investment will be made available, if/when required.

A review of all floor evacuation plans will be conducted, displaying updated information along escape corridors of each compartment and beside the home's fire panel.

Additional Fire Warden Training was scheduled and completed December 06th 2022.

A door performance assessment will be completed by a competent person to confirm door sets that may not provide the required fire performance. Subsequent to same, a repair/replacement programme will be implemented and completed.

Gas pipe in the laundry room was secured to the wall and iron box was removed from the area.

The Emergency Plan will be updated to reflect the risk of fire in the designated centre.

The Registered Provider has engaged the services of a Fire Safety Professional. Means of escape, to include external fire exits will be reviewed to ensure they lead to an area of safety and resident accessible.

Light wells to roof lights over some corridors will be adequately upgraded and fire rated.

Emergency lighting shall be designed, installed and maintained within the residential home in accordance with Irish Standard IS 3217:2013. Records will be maintained and recorded in the Fire Risk Register to include annual certification.

Outstanding recommendations from the periodic inspection will be scheduled and completed.

Confirmation has been provided that Beara and Mizen Compartments consist of 16 and 14 bedrooms respectively. All staff have been made aware and advised of these compartment updates.

Subsequent to Inspection, a fire drill evacuation was demonstrated of our largest compartment (Beara, 16 beds). To ensure continuation of staff knowledge and skills to implement our fire safety strategy and evacuation plan, frequency of fire drills has been increased to fortnightly. Records to reflect this are maintained in the fire safety register.

All resident PEEPs are now updated to reflect specific evacuation needs of the resident and staff resources required to safely evacuate each resident.

A full review of Pictorial Prompt Evacuation Aids for the home has been completed and updated to reflect current resident assessed needs. Regular audits/monitoring will be undertaken by the Director of Nursing to determine compliance to this procedure.

A drill will be scheduled simulating an external exit evacuation utilizing exterior ramped routes.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/06/2023
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	11/01/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service	Not Compliant	Orange	11/01/2023

	provided is safe, appropriate, consistent and effectively monitored.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	05/06/2023
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	28/04/2023
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	05/06/2023
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	13/01/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	05/06/2023
Regulation 28(2)(iv)	The registered provider shall	Not Compliant	Red	23/11/2022

	make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.			
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Substantially Compliant	Yellow	05/06/2023