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:	Newbrook Nursing Home
Name of provider:	Newbrook Nursing Home Unlimited Company
Address of centre:	Ballymahon Road, Mullingar, Westmeath
Type of inspection:	Unannounced
Date of inspection:	25 February 2025
Centre ID:	OSV-0005702
Fieldwork ID:	MON-0042473

About the designated centre

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

Newbrook Nursing Home is registered to accommodate 119 residents. It consists of two separate buildings, a single storey and a two story building known as Newbrook 1 and Newbrook Lodge respectively. It is located in a residential area, within a few minutes drive from the town of Mullingar. Both buildings are surrounded by spacious landscaped gardens and there are secure courtyard garden spaces attached to each building that residents can use safely. One of the courtyards was set out in a traditional shopping streetscape design to provide interest for residents. Residents are accommodated in single and double rooms.

The centre provides care to residents over the age of 18 who have care needs related to aging, dementia, intellectual disability, physical disability and acquired brain injury. Care is provided on a long and short term basis and residents who require periods of convalescence, palliative care or rehabilitation are accommodated.

The aims of the centre as described in the statement of purpose is to provide a high standard of evidenced based care and to ensure that residents live in a comfortable, clean and safe environment that they can consider a "home away from home".

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	117

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
Tuesday 25 February 2025	09:00hrs to 18:30hrs	Kathryn Hanly	Lead
Tuesday 25 February 2025	09:00hrs to 18:30hrs	Gordon Ellis	Support

What residents told us and what inspectors observed

Based on the observations of inspectors and discussions with residents, Newbrook Nursing Home is a nice place to live, where residents are supported to have a good quality of life and have many opportunities for social engagement and meaningful activities. Inspectors spoke with four visitors and 12 residents living in the centre and spent periods of time observing staff and resident engagement over the day of the inspection.

All interactions observed were person-centred and courteous. Staff were responsive and attentive without any delays with attending to residents' requests and needs. Residents spoke of exercising choice and control over their day and being satisfied with activities available. Residents' told inspectors that they said that they could approach any member of staff if they had any issue or problem to be solved.

There was a high level of residents who were living with a diagnosis of dementia or cognitive impairment who were unable to express their opinions on the quality of life in the centre. However, those residents who could not communicate their needs appeared to be relaxed and enjoyed being in the company of staff.

Residents had access to a range of activities for social engagement. Staff were allocated to provide activities for residents, and inspectors saw staff facilitating residents to take part in activities that were offered on the day. Inspectors observed that the residents were supervised in all communal rooms, and residents were encouraged to engage in meaningful activities throughout the day of the inspection.

The centre comprised two separate buildings known as 'Newbrook One' and 'The Lodge'. The location, design and layout of both areas were suitable for their stated purpose and met residents' individual and collective needs. Finishes, materials, and fittings in the communal areas and resident bedrooms generally struck a balance between being homely and being accessible, whilst taking infection prevention and control into consideration.

However, inspectors identified several rooms were services and utilities significantly breached the fire rated construction of walls and ceilings. Large holes were found in high risk areas and what appeared to be an inadequate material and detail had been applied around some openings. This impacted the effective containment of fire and smoke.

Overall the general environment and residents' bedrooms, communal areas and toilets, bathrooms inspected appeared appeared visibly clean and well maintained. The centre was found to be well-lit and warm. The majority of residents had personalised their bedrooms with photographs, ornaments and other personal memorabilia. However, carpets in The Lodge were damaged and had not been steam cleaned following a recent outbreak.

There was a variety of communal spaces in both buildings including, dining rooms, day rooms, sitting room, activity rooms, therapy rooms and a hair saloon. The on-site chapel provided a tranquil space for quiet contemplation and prayer.

Ancillary areas were well-ventilated, clean and tidy and supported effective infection prevention and control. The infrastructure of the on-site laundry supported the functional separation of the clean and dirty phases of the laundering process.

Staff had access to dedicated housekeeping rooms for storage of cleaning trolleys and equipment and sluice rooms with bedpan washers for the reprocessing of bedpans, urinals and commodes.

The kitchens in both buildings were clean and of adequate size to cater for resident's needs. However catering staff changing and toilet facilities required review. Findings in this regard are presented under Regulation 27; infection control.

Hand hygiene facilities supported effective hand hygiene practices. Conveniently located alcohol-based product dispensers along corridors facilitated staff compliance with hand hygiene requirements. Seven new clinical hand washing sinks had been installed at nursing stations to support effective hand hygiene. These complied with current recommended specifications for clinical hand hygiene sinks.

Capacity and capability

This was an unannounced inspection to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). This inspection had a specific focus on the provider's compliance with fire safety and infection prevention and control oversight, practices and processes.

Overall, this was found to be a well-managed centre with a clear commitment to providing good standards of care and support for the residents. Inspectors found that the provider generally met the requirements of Regulation 6: Health care, Regulation 17: Premises, Regulation 25: Temporary absence and discharge and Regulation 27: Infection control, however however further action is required to be fully compliant.

Action is also required to achieve regulatory compliance with Regulation 23: Governance and Management and Regulation 28: Fire Precautions. Findings will be discussed in under the respective regulations.

Newbrook Nursing Home Unlimited Company is the registered provider for this designated centre. The designated centre is registered to accommodate up to to 119 residents. The provider entity was represented by a company director who attends the designated centre regularly. There was a clearly defined management structure in place. The management team consisted of the provider, a regional operations

manager and the person in charge who was supported on site by an assistant director of nursing, clinical nurse managers, nurses, health care assistants, housekeeping, activity, catering, maintenance and administration staff.

There was an adequate number of staff on duty on the day of inspection to provide care for the residents living in the designated centre. Following the last inspection, additional housekeeping staff had been rostered at weekends to ensure a consistent housekeeping service was available throughout the week. This was reflected in the high standards of environmental hygiene observed on the day of the inspection.

Two nurse managers had been nominated to the roles of infection prevention and control link practitioners to support staff to implement effective infection prevention and control and antimicrobial stewardship practices within the centre. Both had completed the link practitioner training.

A comprehensive suite of infection prevention and control audits covered a range of topics including waste management, hand hygiene and environmental and equipment hygiene. Audits were scored, tracked and trended to monitor progress. The high levels of compliance achieved in recent infection prevention and control audits were generally reflected on the day of the inspection.

Weekly care quality indicators which included information regarding the number of wounds and volume of antibiotic use were also maintained on a weekly basis.

Staff had effectively managed several outbreaks and isolated cases of transmissible infections in recent years including two small outbreaks in 2025. Staff spoken with were knowledgeable of the signs and symptoms of infection and knew how and when to report any concerns regarding a resident. A review of notifications submitted to the Authority found that outbreaks were generally managed, controlled and reported in a timely and effective manner.

However, an accurate record of residents with a history of multi-drug resistant organism (MDRO) colonization (surveillance) was not maintained. This meant that staff were unable to monitor the trends in development of antimicrobial resistance within the centre. A review of acute hospital discharge letters and laboratory reports found that staff had failed to identify a number of residents that were colonised with MDROs including including, Carbapenemase-Producing Enterobacterales (CPE), Spectrum Beta-Lactamase (ESBL) and Vancomycin-resistant Enterococci (VRE).

Efforts to integrate infection prevention and control guidelines into practice were underpinned by mandatory infection prevention and control education and training. A review of training records indicated that all staff were up to date with mandatory infection prevention and control training.

Overall this inspection found the number of fire safety risks combined with urgent actions that were identified raised significant concerns about fire safety management in this centre. As a result, the inspectors were not assured that there were adequate measures in place to ensure that residents living in the designated

centre are safe and protected from the risk of fire. These findings are set out under Regulation 28: Fire precautions.

Regulation 15: Staffing

Through a review of staffing rosters and the observations of the inspectors, it was evident that the registered provider had ensured that the number and skill-mix of staff was appropriate, having regard to the needs of residents and the size and layout of the centre. Residents said that there were enough staff to provide the care they wanted at the time they wished.

Judgment: Compliant

Regulation 16: Training and staff development

Records viewed by inspectors confirmed that there was a high level of training provided in the centre. Training courses were a mixture of online and in-person training. All staff had received infection prevention and control and fire training to ensure they had up-to-date mandatory training specific to their roles.

However, inspectors identified, through talking with staff, that further training was required to ensure staff are knowledgeable and competent in the management of urinary catheters, and sharps safety, as detailed under Regulation 27.

Judgment: Compliant

Regulation 23: Governance and management

The findings of this inspection were that the registered provider had failed to put effective and robust management systems in place to ensure that the service provided was safe, appropriate, consistent and effectively monitored, as required under Regulation 23(c).

The oversight of fire safety in the centre was not robust, it did not adequately support effective fire safety arrangements and keep residents safe. This was evidenced by the following:

- The provider had not recognised fire risks found on this inspection. The day to day management of fire risk in the centre did not ensure that risks were identified and managed effectively. These were in regards to significant

issues or faults with fire doors, containment deficiencies, and means of escape, fire precautions, and fire training or evacuation procedures.
- The providers' in-house checks had not identified urgent actions in regards to fire risks that had to be issued to the provider on the day of the inspection. These are outlined in detail under Regulation 28.

Other areas that required improvement in regards to Infection Control were as follows:

- Accurate surveillance of MDRO colonisation was not undertaken. There was some ambiguity among staff and management regarding which residents were colonised with MDROs including CPE, ESBL and VRE. As a result, appropriate precautions may not have been in place when caring for these residents as detailed under Regulation 27; infection control.
- The provider had a Legionella management programme in place. However, water samples were not routinely taken to assess the effectiveness of local Legionella control measures.

Judgment: Not compliant

Regulation 31: Notification of incidents

A review of notifications found that the person in charge of the designated centre notified the Chief Inspector of the outbreak of any notifiable or confirmed outbreak of infection as set out in paragraph 7(1)(e) of Schedule 4 of the regulations, within three working days of their occurrence.

Judgment: Compliant

Quality and safety

Overall, inspectors were assured that residents living in the centre enjoyed a good quality of life. There was a rights-based approach to care; both staff and management promoted and respected the rights and choices of residents living in the centre. All interactions observed on the day of inspection were person-centred and courteous. Residents spoke of exercising choice and control over their day and being satisfied with activities available. Residents were consulted through residents meetings on issues such as the environment, food and mealtimes and activities.

Arrangements were in place to ensure there were no restrictions to residents' families and friends visiting them in the centre and practical precautions were in place to ensure residents were protected from risk of infection.

Residents' health and well-being was promoted and residents had timely access to general practitioners (GP), specialist services and health and social care professionals, such as psychiatry of old age, physiotherapy, dietitian and speech and language, as required. Residents also had access to a mobile x-ray service, with a referral by their GP, which reduced the need for trips to hospital.

The volume of antibiotic use was monitored each month. However, the overall antimicrobial stewardship programme needed to be further developed, strengthened and supported in order to progress. Findings in this regard are presented under Regulation 6; Healthcare.

Resident care plans were accessible on a computer based system. There was evidence that the care plans were reviewed by staff at intervals not exceeding four months. Care plans viewed by inspectors were generally personalised, and sufficiently detailed to direct care.

A version of the National Transfer Document and Health Profile for Residential Care Facilities was used when residents were transferred to acute hospitals for treatment. However, the infection control section was limited to a record of vaccine history and Meticillin resistant *Staphylococcus aureus* (MRSA) status. Other MDROs and infections included on the national transfer document template were not recorded.

Limited and inconsistent information regarding residents infection and colonisation status was also received when residents were discharged from hospital. This increased the possibility of losing critical clinical infection prevention and control information and required an increased degree of coordination between the designated centre and acute hospitals. Findings in this regard are presented under Regulation 25; Temporary absence or discharge of residents.

Inspectors identified some examples of good practice in the prevention and control of infection. Waste and used linen was segregated in line with best practice. Appropriate use of personal protective equipment (PPE) was observed over the course of the inspection.

Equipment was clean and well maintained. The provider had introduced a tagging system to identify equipment that had been cleaned. This system was observed to be consistently implemented at the time of inspection.

The centre was bright, clean and tidy. Improvements had been made to the premises since the previous inspection. For example, seven clinical hand wash sinks had been installed. A schedule of maintenance and painting work was ongoing, ensuring the centre was generally maintained to a high standard.

Notwithstanding the good practices observed, a number of issues were identified which had the potential to impact on the effectiveness of infection prevention and control within the centre. For example, appropriate infection prevention and control procedures were not followed by nursing staff when collecting urine samples from indwelling urinary catheters. Improvements were also required in the oversight and management of residents that were colonised with MDROs, the environment and the

use of sharps. Findings in this regard are presented under Regulation 27; infection control.

This inspection found that the provider's fire safety arrangements did not adequately protect residents from the risk of fire in the centre and did not ensure the safe and effective evacuation of residents in the event of a fire.

The inspectors found fire safety risks on the day of the inspection that had not been identified by the provider. The inspectors noted a number of actions were required in relation to fire precautions, means of escape, staff knowledge, deficiencies to a number of fire doors, building fabric and compartmentation. Some of which could lead to serious consequences for residents in an emergency. Significant effort and resources were now required to ensure that fire risks were addressed in a timely manner.

Regulation 11: Visits

There were no visiting restrictions in place and visitors were observed coming and going to the centre on the day of inspection. Visitors confirmed that visits were encouraged and facilitated in the centre. Residents were able to meet with visitors in private or in the communal spaces through out the centre.

Judgment: Compliant

Regulation 17: Premises

It is acknowledged the provider did make improvements and fulfill commitments identified on a previous inspection. Notwithstanding this, parts of the premises did not conform to the matters set out in Schedule 6 of the regulations and were in need of repair and maintenance, for example;

- Some areas in the centre were found to have holes and penetrations in walls and ceilings.
- Some of the doors and door frames were found to be damaged, had holes or had gaps. The majority of fire doors were missing some seals and some were found to have perished.
- Storage practices required a review. For example, a protected means of escape and a plant room were being used as a storage area. A staff toilet and shower room were being used as a storage area.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

Information regarding residents infection history and colonisation status was not consistently and correctly communicated when residents were transferred to and from the designated centre and actute hospitals. For example;

- The inspectors reviewed transfer documentation and saw that relevant information about the resident's infection and colonisation status was not consistently provided by the designated centre to the receiving hospital. For example; on two occasions a resident's CPE colonisation status was not communicated when the resident was transferred to hospital.
- The infection prevention and control section of the transfer template used by a local hospital focused solely on highlighting MRSA status. A review of transfer letters received found that this section was frequently left blank.

Judgment: Substantially compliant

Regulation 27: Infection control

The provider generally met the requirements of Regulation 27 infection control and the National Standards for infection prevention and control in community services (2018), however, further action is required to be fully compliant. For example;

- Nursing staff told inspectors that the dedicated sampling port was not used to collect urine samples from urinary catheters. Practices described meant that contaminated samples were obtained from drainage bags for testing. This may lead unnecessary and inappropriate antibiotic prescribing.
- Staff were unaware that a several residents were colonised with MDROs including CPE, ESBL and VRE. As a result accurate information was not recorded in resident care plans and appropriate infection control and antimicrobial stewardship measures may not have been in place when caring for these residents.
- Carpets in communal areas in the Lodge were not steam cleaned after a recent outbreaks. National Infection Prevention and Control guidelines advice that a deep clean should be undertaken after outbreaks.
- Catering staff changed and stored their belongings within a toilet. This posed a risk of cross infection particularly in the context of norovirus or other gastrointestinal infections.
- The provider had not introduced a full range of safety engineered sharps devices as an alternative to traditional hallow bore needles. This increased the risk of needle stick injury.
- The detergent in one bedpan washer had expired. This may impact the effectiveness of decontamination.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider was failing to meet the regulatory requirements on fire precautions in the centre and had not ensured that residents were protected from the risk of fire. The provider was non-compliant with the regulations in the following areas:

Day-to-day arrangements in place in the centre did not provide adequate precautions against the risk of fire.

- During the course of the inspection, the inspectors found a number of fire doors in the kitchen area were being wedged open. This created a risk for fire to spread from this area unhindered.
- The inspectors identified two deep fat fryers located in the kitchen however there was no automatic suppression system to deliver localised suppression. This created a risk and required a review by the providers' competent person.
- In The Lodge, a designated smoking room was found to not be fitted with a fire blanket for dousing a potential clothes fire.

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

- In The Lodge, a staircase that appeared to be an accommodation staircase was in use as a protected means of vertical escape and formed part of the evacuation procedure. However the central staircase did not form a protected staircase enclosure that was suitable for protected vertical evacuation. An emergency fire exit sign was also noted to be fitted at the top of the staircase to direct users of the building to use the staircase in the event of a fire.
- The inspectors noted a plant room that directly connected to a protected staircase. This required a review by the providers' competent fire person to ensure the layout of a high risk room directly connecting with a protected staircase was appropriate and did not compromise the means of escape within the staircase. Furthermore, this room was being used as a storage room for maintenance products.
- In The Lodge, an office that overlooked an entrance lobby was fitted with a window hatch that was lacking fire seals. This could potentially compromise the means of escape if a fire occurred in the office.
- In Newbrook 1, an enclosed courtyard was provided with one means of escape. The escape route led residents and staff evacuating the area back into the designated centre through the residents designated smoking area. The inspectors were not assured this was a suitable means of escape. Furthermore, the enclosed courtyard and the fire exit were not provided with emergency lighting to provide adequate illumination during night time hours or emergency directional signage (running man sign) to direct users to the nearest fire exit.

- Internally while an emergency directional signage was provided to the majority of areas, the signage that was provided over two separate fire exits lacked illumination.

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

- The Inspectors identified an internal ESB room (high risk room) located in the kitchen area of Newbrook 1. The room was found with several penetrations and holes through the ceiling. Within the room, a central vacuum system and pipework had been fitted. This had resulted in flammable items being stored in the same small ESB room. The door to this room did not appear to be a fire door. Furthermore, the inspectors were not assured the ceiling in this room would meet the criteria for a fire rated ceiling. The two main fire doors into the kitchen and a door into the lobby adjacent to the ESB room were lacking fire seals. The kitchen door into the dining area had gaps and would not close fully when tested by the inspectors due to ventilation. An urgent action was issued to the provider to address this risk.
- In Newbrook 1, a kitchen lobby area that provided a means of escape to a final fire exit was found to be cluttered with trolleys, brushes, bags of refuse and detergent. This created a potential obstruction and could cause a delay in the event of a fire emergency.
- In The Lodge, fire doors throughout the building were missing cold smoke seals. This included residents' bedrooms, store rooms, office rooms, sluice and high risk rooms. This compromised the effectiveness of these doors to contain the passage of smoke in the event of a fire.
- In Newbrook 1, risks were identified in relation to the overall condition and maintenance of fire doors. The inspectors could not be assured that bedroom areas, offices and store rooms were fitted with a fully compliant fire door assembly. Cross-corridor doors were missing fire seals, some had gaps and some did not close fully or did not align when tested. An urgent action was issued to the provider to address risks in regards to fire doors throughout both buildings.
- A number of final fire exit doors were found to be fitted with key operated locks. Fire exits should provide instant egress in the event of a fire and should be fitted with simple fasteners. This required a review by the providers' competent person.

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

- The Provider had not identified a significant number fire safety risks that were apparent throughout both Newbrook 1 and The Lodge in regards to fire precautions, fire doors, fire containment, appropriate storage practices and means of escape.
- Deficiencies had not been identified on the in-house routine checks of fire safety equipment which resulted in an urgent action being issued to the provider.

The registered provider did not ensure by means of fire safety management and fire drills at suitable intervals, that the persons working in the designated centre and, in so far is reasonably practical, residents are aware of the procedures to be followed in the case of fire.

- All staff were up-to-date with fire safety training and the staff that the inspectors talked with were familiar with the procedure to be followed in the event of a fire. However, on inspection staff when asked in regards to compartmentation boundaries, had assumed that each cross corridor door was a fire compartment boundary and a such staff could move residents beyond these doors to the next compartment in the event of an evacuation. However, the inspectors noted the cross corridor doors in a number of areas would not meet the required fire rating to form a fire compartment. As a result staff had not been given the correct information in respect of how to evacuate residents to a place of safety.. This required a review of staff fire evacuation training to ensure staff had the information they needed to keep residents safe in the event of a fire emergency.

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

- The inspectors identified several rooms where services and utilities significantly breached the fire rated construction of walls and ceilings in both Newbrook 1 and The Lodge. In Newbrook 1, the inspectors noted holes in the ceiling and walls of a boiler room and a hoist store that required sealing.
- In The Lodge, the inspectors identified a number of containment deficiencies to a lift machine room. Large vents had been fitted through a fire rated wall and fire door, penetrations required fire sealing and smoke seals were missing from the fire door into the room. Furthermore, a store room in a entrance lobby and a plant room had several penetrations that required fire sealing to ensure adequate containment of fire and smoke.

In addition to this, the inspectors were not assured the spray foam that had been used to seal around pipework in some areas of the centre was an appropriate fire sealing product or that this work had been carried out by a competent person. This significantly impacted the containment effectiveness of fire and smoke and an urgent action was issued to the provider to address these findings.

- A number of rooms and fire doors that were located along protected means of escape were fitted with glazed vision panels. The inspectors were not assured the vision panels to these areas were of the required fire rating to contain the spread of fire.
- Fire drawings that indicate the location of fire compartment boundaries were not available to the inspectors. As such the inspectors could not be assured that a satisfactory standard of compartmentation was provided or of the extent, size and location of compartment boundaries suitable for progressive horizontal evacuation.
- The inspectors were not assured a series of ceiling and attic hatches would provide the required fire rating. Furthermore, a series of recessed light

fittings along corridors and in various rooms were found to breach the fire rated ceiling. This compromised the integrity of the ceiling.
- Fire detection to a number of toilets along means of escape corridors and in some store rooms located within the protected staircases, while empty did not have fire detection. This required a review by a competent person to ensure adequate detection was provided throughout the centre in line with the fire alarm system requirements.

The displayed procedures to be followed in the event of a fire required a review by the provider.

- While evacuation floor plans and fire action notices were on display, they lacked detail and clarity. The fire drawings did not indicate the location of fire compartment boundaries to be used by staff and residents for progressive horizontal evacuation in the event of a fire.
- Fire action notices and policies required updating as reference was made directing staff to manually turn off gas systems for the kitchen and laundry in the event of a fire. However, the gas systems had been linked to the fire detection alarm system which meant that the gas supply would automatically be shut off in the event of a fire. This could cause unnecessary delay in the event of a fire.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Comprehensive assessments were completed for residents on or before admission to the centre. Care plans based on assessments were completed no later than 48 hours after the resident's admission to the centre and reviewed at intervals not exceeding four months. Overall, the standard of care planning had improved since the last inspection and described person centred and evidenced based interventions to meet the assessed needs of residents.

Judgment: Compliant

Regulation 6: Health care

While antibiotic usage was recorded, there was no documented evidence of multidisciplinary targeted antimicrobial stewardship audits or quality improvement initiatives.

Judgment: Substantially compliant

Regulation 9: Residents' rights

All residents who spoke with inspectors reported that they felt safe in the centre and that their rights, privacy and expressed wishes were respected. Residents rights and choice were respected in the centre and the service placed an emphasis on ensuring residents had consistent access to a variety of activities, seven days a week.

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	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Newbrook Nursing Home OSV-0005702

Inspection ID: MON-0042473

Date of inspection: 25/02/2025

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	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

We have reviewed our fire policy, the implementation of the fire policy, our fire register and the checks to be carried out. The following checks are being carried out in the Centre:

a) Fire exits checked daily for obstructions and other defects.
b) Fire doors are checked weekly for defects.
c) Fire alarm panel is checked daily for faults.
d) The fire alarm is tested weekly by maintenance.
e) The emergency lights are checked daily for non-illuminated lights.
f) A weekly walk around check is being carried out to identify any risks.

Any faults or defects identified during the above checks will have corrective action taken so that they are remedied as soon as possible.

The emergency lights and directional signage have been reviewed and new lighting installed. The Fire Safety Risk Assessment ("FRSA") will cover this in more detail.

A fire blanket has been installed in the smoking room. There is also a fire blanket outside the smoking room adjacent to the door.

Engineers have carried out a FRSA and a Fire Door Survey in March 2025. Once the report has been received a full programme of works will be scheduled for 2025 with priority given to the highest risks first.

The following immediate actions have been taken to address the non-compliances:

1. ESB Room

The vacuum system has been completely removed. The penetrations in the ceiling have been fire sealed on a temporary basis pending the outcome of a fire safety risk assessment ("FSRA").

2. Kitchen Doors

Fire seals have been installed in the kitchen doors on a temporary basis pending the outcome of the FSRA. The door into the dining room has been realigned and now closes fully.

3. Door Wedges

Door wedges in use in the Kitchen have been removed.

4. Deep Fat Fryers

The deep fat fryers have been removed from the kitchen. The following controls are in place:

a. Fire Extinguishers – one class F Wet Chemical extinguisher & fire blanket.
b. Cooker hoods/ grease traps & filters are cleaned at a minimum at least once per week.
c. Flues and ducting are inspected and cleaned by a specialist company once every twelve months.

5. Penetrations

All identifiable penetrations are in the process of being fire sealed. The FSRA will identify other areas that may need to be fire sealed and these will be addressed.

6. Newbrook Lodge Fire Doors

A fire door survey has been carried out as part of the FSRA. Once the report has been received a full programme of works will be carried out on the fire doors.

7. Newbrook (One) Fire Doors

A fire door survey has been carried out as part of the FSRA. Once the report has been received a full programme of works will be carried out on the fire doors.

1. Compartmentation and Compartment Boundaries

The FSRA will cover an assessment of the compartmentation in both buildings. We will also have the floor plans checked against the compartmentation and updated as required. Once the FSRA has been received we will action any required works.

An online B6 PCCE Training – 1/2-day, Fire Door Inspection Course has been sourced by our training facilitator and all maintenance personnel have attended this course in March 2025.

The PIC has reviewed the residents who have an MDRO in the Centre.

A new Antimicrobial Register has been developed for the Centre.

The Care Plans of the residents who have a MDRO Infection have been updated and clearly states the appropriate precautions.

The Infection status of all residents is discussed at handover and the necessary precautions to be in place.

Staff will be supervised to ensure correct precautions are being carried out.

The Legionella Management program now has twice yearly Water Testing included. The Risk and Controls for Legionella have been updated to reflect this

Regulation 17: Premises	Substantially Compliant

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

Engineers have carried out a Fire Safety Risk Assessment ("FRSA") and a Fire Door Survey in March 2025. Once the report has been received a full programme of works will be scheduled for 2025.

An online B6 PCCE Training – 1/2-day, Fire Door Inspection Course has been sourced by our training facilitator and all maintenance personnel have attended this course in March 2025.

The PIC is reviewing all storage practices in the Centre. All means of escape are cleared.

Regulation 25: Temporary absence or discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:

The PIC has reviewed the Transfer Documentation regarding infection status.
The status of infection is added to the medical history of all residents, this now populates onto the transfer letter, to ensure infection status is communicated from the Nursing Home to Hospital.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

.
Staff have attended refresher training in relation to catheter care.

The PIC and Infection Control leads in each building will inform and educate all staff on MDRO'S. All care plans have been updated to accurately reflect infection status and precautions.

All staff will continue to attend Infection Control Training. Additional Infection Prevention Control Training for Nurses within Long-Term Residential Care has been identified for nurses to attend.

The infection status of all residents is discussed at handover and the necessary precautions to be in place. Staff will be supervised to ensure correct precautions are being carried out.

The carpets in the communal areas in The Lodge are currently being removed and replaced with Vinyl Flooring.

Lockers and changing areas for catering staff are under review and alternatives are being explored.

Safety Needles have been sourced and ordered.

The household staff will check the detergent level on the bedpan washer weekly.

Regulation 28: Fire precautions	Not Compliant

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

We have reviewed our fire policy, the implementation of the fire policy, our fire register and the checks to be carried out. The following checks are being carried out in the Centre:

a) Fire exits checked daily for obstructions and other defects.
b) Fire doors are checked weekly for defects.
c) Fire alarm panel is checked daily for faults.
d) The fire alarm is tested weekly by maintenance.
e) The emergency lights are checked daily for non-illuminated lights.
f) A weekly walk around check is being carried out to identify any risks.

Any faults or defects identified during the above checks will have corrective action taken so that they are remedied as soon as possible.

Engineers have carried out a Fire Safety Risk Assessment ("FRSA") and a Fire Door Survey in March 2025. Once the report has been received a full programme of works will be scheduled for 2025 with priority given to the highest risks first.

A fire blanket has been installed in the smoking room. There is also a fire blanket outside the smoking room adjacent to the door.

We are carrying out a review of the fire alarm system to identify any upgrade works that are required.

We are reviewing the means of escape, emergency lights and directional signage in the Centre as part of the FSRA. The fire action notices, floor plans and evacuation notices are being reviewed and amended as necessary. Pending receipt of the FSRA we have taken the following interim measures:

a) We have revised our evacuation plan for the Lodge so that the central staircase is not used as a means of vertical escape. We have removed the emergency fire exit sign at the top of the stairs.
b) The plant room off the protected staircase in the Lodge has been decluttered and will not be used for maintenance products.
c) The office window hatch is being assessed by our engineers and once we have their recommendations we will make any necessary improvements.
d) Running man signs and emergency lighting is being installed in the enclosed courtyards as required.
e) We are prioritising a review of the compartment doors with our engineer. Once this is done we will immediately review the fire evacuation training. We expect this to be completed by the 9th May 2025.

The following immediate actions have been taken to address the non-compliances:

1. ESB Room

The vacuum system has been completely removed. The penetrations in the ceiling have been fire sealed on a temporary basis pending the outcome of a fire safety risk assessment ("FSRA"). Consulting Engineers have carried a FSRA. We await their report. All work required from the FSRA will be actioned immediately.

2. Kitchen Doors

Fire seals have been installed in the kitchen doors on a temporary basis pending the outcome of the FSRA. The door into the dining room has been realigned and now closes fully.

3. Door Wedges

Door wedges in use in the kitchen have been removed.

4. Deep Fat Fryers

The deep fat fryers have been removed from the kitchen. The following controls are in place:

a. Fire Extinguishers – one class F Wet Chemical extinguisher & fire blanket.
b. Cooker hoods/ grease traps & filters are cleaned at a minimum at least once per week.
c. Flues and ducting are inspected and cleaned by a specialist company once every twelve months.

5. Penetrations

All identifiable penetrations are in the process of being fire sealed. The FSRA will identify other areas that may need to be fire sealed and these will be addressed.

6. Newbrook Lodge Fire Doors

A fire door survey has been carried out as part of the FSRA. Once the report has been received a full programme of works will be carried out on the fire doors. We have engaged a contractor to carry out this work.

7. Newbrook (One) Fire Doors

A fire door survey has been carried out as part of the FSRA. Once the report has been received a full programme of works will be carried out on the fire doors. We have engaged a contractor to carry out this work.

8. Compartmentation and Compartment Boundaries

The FSRA will cover an assessment of the compartmentation in both buildings including fire doors, attic hatches, recessed lighting and attic spaces. We will also have the floor plans checked against the compartmentation and updated as required. Once the FSRA has been received we will action any required works.

An online B6 PCCE Training – 1/2-day, Fire Door Inspection Course has been sourced by our training facilitator and all maintenance personnel have attended this course in March 2025.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

PIC and CNM are the Infection Control leads and will take on board responsibility for the antimicrobial stewardship for 2025.

The following has been put in place.
• New MDRO Register
• Antibiotic Use Audit for 2025 has been implemented and actions from this will serve as Quality Improvement Initiatives in this area.
• AMRIC Education Folder.
• An Infection Prevention Surveillance Committee will meet monthly.
• Additional Infection Prevention Control Training for Nurses within Long-Term Residential Care 2025.

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	31/08/2025
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	15/04/2025
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated	Substantially Compliant	Yellow	15/04/2025

	centre from which the resident is temporarily absent shall ensure that all relevant information about the resident is provided to the receiving designated centre, hospital or place.			
Regulation 25(2)	When a resident returns from another designated centre, hospital or place, the person in charge of the designated centre from which the resident was temporarily absent shall take all reasonable steps to ensure that all relevant information about the resident is obtained from the other designated centre, hospital or place.	Substantially Compliant	Yellow	15/04/2025
Regulation 27	The registered 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.	Substantially Compliant	Yellow	30/09/2025
Regulation 28(1)(a)	The registered provider shall take adequate	Not Compliant	Red	31/07/2025

	precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/09/2025
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.	Not Compliant	Red	31/07/2025
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/09/2025
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire	Substantially Compliant	Yellow	30/09/2025

	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(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	28/02/2025
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Substantially Compliant	Yellow	30/09/2025
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Substantially Compliant	Yellow	30/06/2025