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:	Portiuncula Nursing Home
Name of provider:	Newbrook Nursing Home Unlimited Company
Address of centre:	Multyfarnham, Westmeath
Type of inspection:	Unannounced
Date of inspection:	11 March 2025
Centre ID:	OSV-0000084
Fieldwork ID:	MON-0043223

About the designated centre

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

Portiuncula Nursing Home is a purpose-built two-storey facility located in Multyfarnham Village, close to Mullingar town. The centre opened in 2004 and is under the management of Newbrook Nursing Home company. It is registered for 60 beds. The designated centre provides long-term 24-hour general care and short-term convalescence and respite care to a range of male and female residents over 18 years of age with dementia, intellectual disability, acquired brain injury and palliative care. The accommodation is provided in 47 single rooms, five twin rooms and one three bedded room across the two storeys. All bedrooms have en suite facilities. The centre has a team of medical, nursing, direct care, and ancillary staff, as well as access to other health professionals to deliver care to the residents. The philosophy of the centre is to provide a high standard of care in a living environment that residents 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:	56

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 11 March 2025	09:00hrs to 18:00hrs	Celine Neary	Lead
Tuesday 11 March 2025	09:00hrs to 18:00hrs	Gordon Ellis	Support

What residents told us and what inspectors observed

The inspectors met with a number of residents who were complimentary about their life in the centre and the services they received. Residents told the inspectors that they enjoyed living in this centre and that they "felt safe". Residents gave positive feedback and were complimentary about the person in charge, staff and the care provided in the centre. The inspectors also spoke with visitors and they were very complimentary of the service and care provided.

On arrival at the centre, the inspectors were greeted by the person in charge and assistant director of nursing. Following a formal introductory meeting about the service, the inspectors did a walk around of the centre. This gave inspectors the opportunity to inspect the premises, observe staff practices and speak with residents and staff.

Inspectors observed that staff were kind and respectful in their approach to providing care and support. Residents were consulted and offered choices regarding their care, and a person-centred approach was taken into account by staff. Each member of staff was knowledgeable and aware of residents care needs and preferences. Residents appeared relaxed and comfortable in the presence of staff.

Portiuncula Nursing Home is a two-storey building set in the countryside and is within close proximity to Mullingar town, County Westmeath. The centre is situated beside a Franciscan church and abbey. Residents can enjoy picturesque views of the surrounding area and green fields. The nursing home is well-established and has been part of the community for several years. It is supported by the local community with visits from community groups and schools scheduled throughout the year.

Two meal times were observed by inspectors. Meal-times were well organised and were a social occasion for many residents who enjoyed dining and chatting together. Residents told the inspectors that they looked forward to attending the dining room and meeting with other residents as part of their day. Daily meal menus were on display and dining staff also advised residents regarding the menu available to support residents to make choices regarding their meals. Staff provided support and discreet assistance in the dining room and were observed sitting beside and interacting with residents, which was in keeping with the social aspect of the meal time experience.

A social activities programme was observed being carried out in the communal room on the day of the inspection. Inspectors observed that the majority of residents took part in these activities and appeared to enjoy them. Some residents went out on a trip with staff to get ice-cream.

Residents were given the opportunity to access television, radio and newspapers. Many residents' bedrooms were personalised with photographs and personal belongings, including their photographs, artwork and ornaments.

Residents' visitors were made welcome and were seen by the inspectors coming and going throughout the day of the inspection.

Following the first day of the inspection, an urgent compliance plan request was issued to the registered provider in respect of significant and immediate fire safety risks and associated non-compliance with Regulation 28: Fire precautions.

The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in place and how these arrangements impact on the quality and safety of the service being delivered.

Capacity and capability

Overall, this was a well-managed centre, with residents' needs and preferences central to the daily routines and the organisation of the centre. This centre has a good history of compliance, and any outstanding actions from previous inspections had been appropriately followed up by the provider. However, some improvement was required in relation to the management systems in place, staffing, training and fire safety precautions.

This was an unannounced 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 unsolicited information received by the Chief Inspectors office. This information was not substantiated on this inspection.

The registered provider is Newbrook Nursing Home Unlimited Company. There was a clearly defined management structure in place in the centre. There had been a change in the governance and management arrangements in the centre since the last inspection. The person in charge was now supported in their role by an assistant director of nursing. The provider also has a senior management team operating at group level, including an operations manager who supports the management teams working in each centre. There is also support available from the group training department and the human resources (HR) and finance teams.

The person in charge is a registered nurse with the required management qualifications and experience for the role. They facilitated the inspection on the day, with the support of an assistant director of nursing. Both had been working in the centre for several years.

The information requested by the inspectors on the day of the inspection was made available in a timely and organised manner. The provider and person in charge had

systems in place to ensure that they had oversight and governance of the quality of care received by residents. However, a review of the audit systems in place was required to ensure that detailed action plans were developed as part of a quality improvement plan. The provider had been proactive and was in the process of reviewing the auditing system in place.

The provider ensured that resources were made available to provide care and services in line with the statement of purpose against which the centre was registered. There were enough skilled and knowledgeable staff to provide safe and appropriate care for the 57 residents living in Portiuncula Nursing Home on the day of the inspection. However, inspectors were not assured that the night time staffing arrangements were adequate in the event of a fire emergency, taking into account the size and layout of the centre, which was spread out over two floors. Furthermore, it was identified that a high number of falls occurred during these hours and this required further review by the provider. This finding is discussed under Regulation 15: Staffing.

There was a varied training programme in place to ensure staff were appropriately skilled. From a review of the training records, it was identified that not all staff had completed their mandatory training, such as fire safety and fire drills, manual handling or cardio-pulmonary training (CPR). Additional training, such as childrens first and infection prevention and control training had been completed.

The statement of purpose had been updated in line with the regulations and contained all of the required information.

The majority of notifications required to be submitted to the office of the Chief Inspector were done so in accordance with regulatory requirements. However, the inspectors found that some serious injury incidents had not been notified to the Chief Inspector, as required by Regulation 31.

The centre's complaints management policy and procedure had been updated to reflect the amendments to the regulations. A record of complaints was maintained, which demonstrated that complaints were managed effectively. There was one open complaint at the time of inspection.

Regulation 15: Staffing

Inspectors were not assured that there were enough staff on duty from 8pm until 8am to ensure that residents' needs were addressed promptly, taking into account the size and layout of the designated centre. For example, there were 96 falls in the centre in 2024, and 62 of these falls had occurred between the hours of 8pm and 8am when staffing levels were at their lowest.

Furthermore, inspectors could not be assured that four staff on duty at night time could safely evacuate residents from the first floor or ground floor, in the event of a

fire emergency and therefore, an urgent action plan was issued to the provider following the inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

Training records reviewed on the day of the inspection evidenced some gaps in mandatory training for staff. In particular:

- Five staff required manual handling training.
- Thirteen staff required cardio-pulmonary training.
- Training was required in fire evacuation procedures for 11 staff, specifically, ensuring that the largest compartment in the centre could be evacuated with reduced staffing levels, as actioned under Regulation 28.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider did not ensure that the service had sufficient staffing resources to:

- Ensure the staffing levels at night were adequate to provide safe care and evacuation of the centre in the event of a fire emergency.
- To provide appropriate supervision and care of residents from 8pm to 8am when staffing levels were at their lowest.

Governance and management systems were not effectively monitored. For example;

- Audits completed contained limited details and did not assure inspectors that actions taken had improved the issues or risks identified.
- There was not adequate oversight of staff training to ensure that staff had access to appropriate training and training was implemented.

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 regard to significant issues or faults with fire doors, containment deficiencies, means of escape, fire precautions, staff resources 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. These are outlined in detail under Regulation 28.
- An urgent action plan was issued to the provider following the inspection in respect of the findings under Regulation 15: Staffing and Regulation 28: Fire precautions. The responses to the urgent action plan submitted by the provider did provide sufficient assurances.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had an up to date statement of purpose in place that included the information required in Schedule 3 of the regulations. The statement of purpose was available for residents and families.

Judgment: Compliant

Regulation 31: Notification of incidents

Not all incidents required to be notified to the Chief Inspector were notified. During the inspection, the inspectors identified that two notifiable incidents had occurred; however, the office of the Chief Inspector had not received the appropriate notification.

Judgment: Not compliant

Regulation 34: Complaints procedure

A complaints policy and procedure was available in the centre, which had been updated in line with recent legislative changes. The policy identified the complaints officer, and the review officer and outlined the process for managing complaints.

The registered provider maintained records of complaints made in relation to the service. These records contained all of the information required by the regulations,

including the investigations carried out and any improvement plans developed. The satisfaction of the complainants with the outcome of complaint investigations was also recorded. Advocacy services were made available to complainants to support them in making a complaint if required. There was one open complaint at the time of inspection which had been referred to a third party.

Judgment: Compliant

Quality and safety

Overall, the inspectors were assured that residents were supported and encouraged to have a good quality of life in the centre. The inspectors found that although improvements had been made across some regulatory requirements further actions were required.

The design of the premises was suitable for the residents' needs with wide corridors, sufficient and spacious communal rooms and a secure outdoor garden. Areas of improvement to the premises identified on the previous inspection had been addressed by the provider; however, some further areas required attention, such as the design of two multi-occupancy bedrooms, which are detailed under Regulation 17 and 9.

The centre was generally visibly clean, and infection prevention and control policies and procedures were in place. There were sufficient cleaning staff on duty, and they were knowledgeable about the required control measures. However, a review of infection prevention and control measures in place on the first floor required review to ensure effective cleaning of healthcare utensils.

Residents had an assessment of their needs completed on admission to the centre to ensure the service could meet their health and social care needs. Following admission, a range of clinical assessments were carried out using validated assessment tools. The outcomes were used to develop an individualised care plan for each resident which addressed their individual health and social care needs. A sample of residents' records were reviewed, and inspectors found that care plans reflected person-centred guidance on the current care needs of residents. Care plans were initiated within 48 hours of admission to the centre, and reviewed every four months or as changes occurred, in line with regulatory requirements. Nursing and care staff were knowledgeable regarding the care needs of the residents.

Residents were provided with good standards of nursing care and support to meet their assessed needs. Residents' records and their feedback to the inspector confirmed that their needs were comprehensively assessed, and they had timely access to their general practitioners (GPs), specialist medical and nursing services, including psychiatry of older age, community palliative care and health and social care professionals as necessary.

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, evacuation, deficiencies to a number of fire doors, building fabric and compartmentation. Some of which could lead to serious consequences for residents in an emergency.

Overall this inspection found the number of fire safety risks combined with urgent actions that were identified raised significant concerns about fire safety management and oversight 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. Significant effort and resources were now required to ensure that fire risks were addressed in a timely manner.

There was a variety of activities available to residents, which included group and one-to-one sessions. Activity provision in the centre was of a good quality, with a range of activities on offer during the week, coordinated by dedicated activities staff.

Staff interactions with residents were respectful and empathetic which helped to promote a culture of openness and inclusiveness in which residents were respected and safeguarded. Measures were in place to safeguard residents from abuse. Members of staff who spoke with the inspectors were familiar with the procedures to be followed should a safeguarding concern arise at the centre. Residents said that they felt safe and that they could talk to a member of staff if they were concerned about anything.

Regulation 17: Premises

Some areas of the premises did not conform to the requirements set out in Schedule 6 of the regulations as follows;

- Maintenance was required to some fire doors and some areas had unsightly breaks and holes in walls and ceilings around services that required repair and redecoration to improve the appearance and to ensure adequate containment of fire.
- A section of flooring in a sitting room was damaged and needed repair.
- The inspectors noted a sluice room located on the first floor was not provided with a sluice machine.
- The design and layout of one triple bedroom, number 138, and a twin bedroom, number 240 did not support personal space or privacy and dignity of residents sharing these bedrooms.

Judgment: Substantially compliant

Regulation 27: Infection control

Some actions were required to ensure that infection prevention and control procedures were consistent with the National standards for infection prevention and control in community services as published by the Authority. There was no sluice machine available to staff on the first floor to appropriately clean and sanitise urinals or bedpans following use, for 29 residents. This increases the risk of cross infection and contamination.

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 fire door in a kitchen was wedged open. This created a risk for fire to spread from this area unhindered as the closing mechanism had been impeded.
- The inspectors observed hoists were charging in a corridor. This created a potential fire risk and could potentially compromise a protected means of escape in the event of an evacuation.
- There was a lack of signage to indicate the location of the gas shut-off in the kitchen. In addition, staff had to leave the kitchen and go to a nearby locked store room in order to access an electrical unit to shut-off electricity to the kitchen area. This required an assessment, to provide assurance that there is no delay in the event of an evacuation. Furthermore, the inspectors observed cardboard boxes were stored in front of the electrical unit.
  This would potentially impede access to the electrical unit. The location and access should be readily available and obvious to staff in order to access shut-off switches in a fire emergency.
- 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 an Oratory, used by residents, the inspectors found candles and a box of matches unattended. This created a risk to residents with cognitive or dementia symptoms having access to a fire starting implement.

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

Externally, the inspectors were not assured there was adequate emergency lighting provided to the majority of external areas in order to provide illumination in the event of a night time evacuation and ultimately the safe placement of residents at the designated fire assembly point. This was evident at the front entrance, rear and side areas of the centre.

Escape routes were obstructed in some areas, by stair gates. This created a risk of obstructing or delaying a vertical evacuation. The assessment of the impact of stair gates on escape routes during an evacuation required a review by the provider.

Some fire exits had a raised threshold and in one case the door frame itself was left for residents to step over in the event of an evacuation. This would not be suitable as a means of escape for all residents who would require a range of evacuation aids such as a bed, a wheelchair or a zimmer frame. This would cause an obstruction or a delay in an evacuation.

On the first floor, the inspectors noted a store room was located within a designed escape staircase. This required a review by the providers' competent fire person to ensure the layout of a store 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 and communications. In addition, the maintenance materials were stored behind a fire rated door that, failed to close fully, was missing smoke seals and there were a number of unsealed service penetrations within the store room.

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

- An external evacuation route at the side of the designated centre was covered in mud. This created a slip hazard to residents who would have a range of evacuation aids and mobility concerns in the event of an evacuation.

- The majority of fire door sets throughout the building were missing cold smoke seals. This included residents' bedrooms, cross-corridor doors, store rooms, office rooms, sluice and high-risk rooms. Some fire doors were found to be missing a door closing mechanism and were fitted with non-fire rated ironmongery.

The inspectors identified several rooms where holes, services and utilities significantly breached the fire-rated construction of walls and ceilings. This was evident in a number of store rooms and high risk rooms. In addition to this, the inspectors were not assured the spray foam that had been used to seal around pipe work and infill large openings 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 this finding.

An urgent action was issued to the provider to address these findings.

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

- The provider had not identified a significant number of fire safety risks that were apparent throughout the designated centre in regards to fire precautions, fire doors, fire containment, staff resources and evacuation procedures.
- Deficiencies had not been identified during the in-house routine checks, which resulted in an urgent action being issued to the provider.
- Arrangements for staff to attend fire training required improvement by the provider. From a review of fire training records, the inspectors noted one staff member was due refresher mandatory fire training and several staff had not attended a fire evacuation drill, two of which were rostered under periods of low staffing numbers.

The registered provider did not ensure, by means of fire safety management and fire drills at suitable intervals, that persons working in the centre and in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of a fire. For example:

- From a review of the drills, the inspectors were not assured that staff are adequately prepared for the scenarios that are likely to be encountered by them in the event of a fire in the centre, taking into consideration residents' dependency levels, evacuation procedures and staffing resources rostered under periods of low staffing numbers. As there was only one fire panel located on the ground floor, the evacuation times recorded were not accurate. The time it would take for staff to leave the first floor, refer to the fire panel, and investigate a potential fire on the first floor and return to inform the senior staff on the ground floor was not reflected in the drill time.

Furthermore, it was not clear from the drills if vertical evacuations had been trialled on the various escape stairs or if the drill was only into the landing of the protected staircases. In regards to staff knowledge, inconsistencies were presented when staff spoke of the evacuation procedure, the location of compartment boundaries to move residents beyond in the event of an evacuation, and the arrangements for staff to supervise residents on the first floor in a scenario where staff have to leave and attend the fire panel on the ground floor. As a result, the inspectors could not be assured that adequate fire training, evacuation procedures and drill practices were being provided.

The registered provider did not make adequate arrangements for detecting or containing fires. For example:

- 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 that the extent, size and location of compartment boundaries were 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 in various rooms were found to breach the fire rated ceiling. This compromised the integrity of the ceiling.
- Fire detection was not in place in some areas of the centre including two store rooms and a sluice room. This is a repeated finding from a previous inspection and required a review by a competent person to ensure adequate detection was provided throughout the centre in line with the fire alarm system requirements.

Containment issues were noted to doors at the centre, for example; large gapping around the perimeter, and underneath doors was apparent. This included bedroom doors, store rooms, compartment doors, staircase doors and doors into a kitchen area. A fire door to a lift machine room appeared to be modified with a non-fire rated ventilation grill.

Non-fire-rated doors were fitted to a house keeping room and an office that was being used to charge hoist batteries. Non fire rated glazing was found above fire doors into the kitchen area and Georgian vision panels were noted on 60 minute cross corridor doors. Some fire doors were damaged which would impact on the fire resistance of the door. This compromised the effectiveness to contain the passage of smoke and fire.

In a water treatment room and a lift machine room, unsealed service penetrations were noted that compromised the containment measures and required fire sealing. In a lift machine room, gaps were noted between a plaster boarded wall enclosure, that had been filled with a spray foam product. Large holes were noted in the water treatment room, which were also filled with a spray foam product.

An urgent action was issued to the provider to address these findings.

Arrangements for evacuating all persons in the designated centre and safe placement of residents in the event of a fire emergency in the centre were not adequate. For example:

- The inspectors were informed that four staff were rostered on night-time duty to care for the 56 current residents (the designed centre is registered for 60 residents). From a review of the registered floor plan, there were 31 beds on the ground floor and 29 beds currently registered on the first floor. It was evident from reviewing residents' evacuation requirements that a number of residents on the ground and first floor required between 2, 3 and 4 staff members to assist in their evacuation. In particular, on the first floor two residents required 3 to 4 staff members to assist in their evacuation.

Taking the following considerations into account; the sprawling layout of the centre over two floors, the location of residents who required additional staff in an evacuation, some up to 3 and 4 staff members on the first floor, one fire alarm panel being provided for the entire centre located on the ground floor, the current staffing resources on duty at night time, the lack of staffing resources at night to adequately supervise the remaining residents in the centre during an evacuation, to meet the fire brigade, to supervise residents in other areas of the centre and at the assembly area and the current totality of the fire risks in the centre. As a result, the inspectors could not be assured that adequate measures were in place to evacuate residents with the staffing resources in a reasonable and safe manner.

An urgent action was issued to the provider to address these findings. It is acknowledged the provider added an additional staff member on duty. However, further improvements were still required to address the range of risks as outlined above.

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

Floor plans on display did not indicate the location of call points or the location of fire extinguishers. Fire action notices were lacking throughout the centre and the action notices that were on display were not accurate as reference was made to the gas system that stated the system would automatically turn off as it was linked to the fire alarm system. However, this was not the case as it required staff to manually turn it off. Furthermore, fire evacuation floor plans and zoned floor plans were not on display at the main fire panel.

This could cause confusion and delay for staff to refer to in the event of a fire. As such, floor plans and fire action notices require a review.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Residents' care plans were developed following assessment of need using validated assessment tools. Care plans were seen to be person-centred, and updated at regular intervals.

Judgment: Compliant

Regulation 6: Health care

Residents were provided with timely access to a medical practitioner and health and social care professional services in line with their assessed needs.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights for privacy and dignity and to undertake personal activities in private were not supported in the two multi-occupancy bedrooms due to the design and layout of one triple bedroom, number 138, and a twin bedroom, number 240. Futhermore, these bedrooms lacked storage for residents and many items were stored on the floor or on top of units.

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	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	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	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Portiuncula Nursing Home OSV-0000084

Inspection ID: MON-0043223

Date of inspection: 11/03/2025

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: An additional HCA has been rostered on night duty. The PIC is conducting an in-depth analysis of falls that occurred at this time of day. A quality improvement plan will be developed and implemented from these findings. We have increased staff levels pending a full review of: • The current PEEPs. • The fire drills recently carried out for simulated night-time evacuations. • The compartmentation of the Centre. • Further fire training. • Further fire drills to assess evacuation procedures. • The scheduled FSRA and fire door survey. • Remedial works required to the building.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The PIC has reviewed training, and all required training is scheduled for 2025. Training has been delivered since inspection both mandatory and relevant to role: • Manual Handling • CPR • Fire Training	

Fire drills form an integral part of the fire training and fire drills are focused and specific in relation to compartment size. We have carried out simulated nighttime drills for the largest compartment.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
An additional HCA has been rostered on night duty. The PIC is conducting an in-depth analysis of falls that occurred at this time of day. A quality improvement plan will be developed and implemented from these findings.

We have increased staff levels pending a full review of:

- The current PEEPs.
- The fire drills recently carried out for simulated night-time evacuations.
- The compartmentation of the Centre.
- Further fire training.
- Further fire drills to assess evacuation procedures.
- The scheduled FSRA and fire door survey.
- Remedial works required to the building.

Any audits carried out will have actions with an improvement plan developed where required.

The PIC will oversee, plan and co-ordinate all staff training for 2025.

Management Systems
The Provider and PIC have reviewed and actioned the fire safety arrangements in the centre since inspection. The following actions and improvements have been implemented to maintain effective fire safety arrangements. Evidence of actions are as follows :
- The Provider had Engineers on site and complete a Fire Safety Risk Assessment and a Fire Door Survey in April 2025 .The results of this report are due in May 2025 .Once this report has been received the risk rating of the actions on this report will formulate the course of work for the remainder of 2025 .The highest risks will be prioritised as a matter of urgency .
- The PIC has Risk assessed the largest compartment of the centre and this does not exceed 8 residents.
- The PIC has risk assessed all Residents PEEPS Residents who are at higher risk due to dependency level or mobility have been consulted with rationale and moved to accommodation from the First floor to the ground floor to reduce any risk of delay in the event of a Fire Emergency or Evacuation .

• The PIC/Deputy PIC conduct a daily walk around of the centre
• The Provider and the PIC conduct a Safety Walk around of the centre at a minimum of 6 weeks.
• The Risk Register has several risks in place in relation to Fire with suitable controls. Post inspection a new Fire risk (Fire Safety -Reg 28 Compliance) has been created .This risk will serve as a tool to action all planned works to reach Fire safety compliance.
• Fire Safety is discussed at all Governance and Management meeting onsite post walk around.

Governance and Management Improvements

The Provider and PIC have examined the current fire Safety Management systens and have initiated the following actions to ensure the centre has a robust approach to Fire Safety at all times .The actions initiated to date are as follows:

• Resident Personal Emergency Evacuation Plans (PEEPS) updated in March/April 2025 to reflect the ability of the resident ,the level of staff assistance required , number of staff required ,method of evacuation ,equipment ,supervision required .The updated PEEPS have been communicated to all staff at Handover, Fire Drills and Fire Training The resident PEEPS are available in Folder/Computer .
• Fire training completed on 26.03.2025, 02.05.2025 and planned for the rest of year
• Fire Drills have been conducted and all staff have a minimum of 2 Fire Drills completed a year.
• Fire Drills to check staff ability and competence - completed
• Night simulated Drills - completed
• Fire Drills of the largest compartment -completed
• Online Fire Training B6 PCCE training (Fire Door Inspection and Maintenance course) provided and completed for Maintenance staff on 24.03.2025 ,a second course is planned for 16.06.2025.

Day to Day Fire Improvements

The Provider and PIC have reviewed the implementation of the Fire Policy and the daily Fire systems at the centre .In accordance with the Fire policy the PIC will direct and supervise the daily checks in the Fire Book .The following checks are being implemented in the centre as follows:

• A Staff member is allocated daily as the Fire Officer for the centre (Nurse)
• A Staff member is allocated each night as the Fire Officer for the centre (Nurse)
• Fire Panel checked daily and at night (Nurse)
• Fire Exits checked daily and at night for any obstructions or defects (Nurse)
• Fire Doors are checked weekly for defects (Maintenance)
• Fire Alarm tested Weekly (Maintenance)
• Fire Door opening/closing mechanisms are checked weekly (Maintenance)
• Emergency Lighting checked daily and at night for any faults in relation to non-illuminated light (Nurse, All staff ,Maintenance)
• The Fire Book is completed daily ,weekly and monthly (Nurse/Maintenance)
• All Fire risks reported to the PIC /Provider (All Staff)
• A weekly walk around check is conducted to identify and risk (PIC/Deputy PIC)
• Fire Inspections have been conducted as part of the periodic requirements by a competent person and certificates on site -Electrician

Provider actions to date

• An additional HCA has been rostered on night duty
• Staff on night duty have attended Fire Training and Fire Drills

Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: All notifiable incidents will be reported to the chief inspector.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The FSRA and fire door survey will produce a program of works for fire safety. Resources have been allocated to address the remedial works required. The sitting room flooring has been repaired. A bed pan washer has been ordered for the first-floor sluice room. The triple bedroom 138 has been reviewed. We will only admit two residents into this room. We will apply to vary the registration and re-register the bedroom as a twin room. Twin bedroom 240 has been reviewed. We are reconfiguring the privacy curtain to make better use of the space in the room to meet the needs of the residents.	
Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: A bed pan washer has been ordered for the first-floor sluice room.	
Regulation 28: Fire precautions	Not Compliant

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

• Fire Doors: Engineers have been retained to carry out a fire safety risk assessment ("FSRA") which will include a full fire door survey of the Centre. The dates for this survey have been confirmed to be the 20th and 24th March 2025. The survey has been completed, and we await the report. Once the report is received, we will carry out a full programme of works on the fire doors.

• Penetrations: All identifiable penetrations are in the process of being fire sealed. I expect that this immediate work will be completed by the 27th of March 2025. The FSRA will identify all further areas that need to be addressed.

• Compartmentation and Compartment Boundaries: The FSRA will cover an assessment of the compartmentation in the Centre. The floor plans will be checked against the compartmentation and updated as required.

• Staffing Resources: We have reviewed staff levels pending a full review of:

a. The current PEEPs.
b. The fire drills recently carried out for simulated night-time evacuations.
c. The compartmentation of the Centre.
d. Further fire training.
e. Further fire drills to assess evacuation procedures.
f. The scheduled FSRA and fire door survey.

An additional HCA has been rostered from 19:45 to 08:15 to provide additional assistance with the evacuation of residents. We will re-assess staffing levels once the above has been carried out.

The Provider and PIC have reviewed and actioned the regulatory requirements on Fire precautions in the centre to ensure residents are protected from the risk of fire.Immediadte actions have been implemented where possible to address the non complaince risk followed by Interim and planned actions :
• Day to Day arrangements :A staff member is allocated to be the Fire Officer daily .The daily Fire checks are completed and signed in the Fire Book -completed
• Kitchen Fire Door -This wedge has been removed-completed
• Hoists:The Residents Moving and Handling Hoists are under review by the PIC and an altrenative and suitable area on the ground floor is being identified -June 2025 .
• Signage: The Kitchen signage has been reviewed and a Gas Shut Off sign is in place to alert all staff to its location at all times and in the event of a Fire.
• Electrical :The FRSA will assess the electrical unit in the nearby store room. The cardboard boxes in front of the electrical unit have been removed.
• Deep Fat Fryers: Both deep fat fryers have been removed.
• Oratory: The Candles and box of matches have been removed and the PIC will make

available only at religious cermonies ,Battery operated candles will also be made available -completed
• Emergency Lighting : The external emergency lighting at the front enterance ,rear and side of building has been upgraded -completed
• Escape Routes : All escape routes have been risk assessed and at present the Stair Gates serve as a safety feature not to restrict staff or residents but to prevent any incident or accident such as falling from a height .The PIC and Fire Training Officer have risk assessed these and they will reamain in place as a safety control pending FSRA report .
• Fire exits: The raised threshold at the fire exit will be removed.
• First Floor Store room: This was reviewed by the engineer in the Fire Safety Risk Assessemnt conducted in 2025. We will action and follow recomendations for this area. Since inspection this room has been decluttered and contains a minimum of maintenace products .This Fire door has been checked and adjusted to close properly. All identifable penetrations are in the process of being sealed .The FSRA will identify all penetrations in the building and this will from as a plan of works as a matter of priority.
• External evacuation Route : At the side of the building which was covered in mud has been cleaned-completed
• Fire Doors: The provider acknowledges the inspectors notes in relation to the lack of cold smoke seals in some of the doors in the Centre. A carpenter has been employed to adjust the fire doors, install cold smoke seals and change iron mongery.
• Fire Door Closing Mechanisms: All doors now have closers fitted.
• Walls and Ceilings: Fire sealing works have commenced and are being carried out by a competent person.
The Provider has reviewed all fire precautions in the Centre and has completed or actioned the followng risks:
• Fire Safety Deficiencies :Staff Resources:In house checks are in progress ,deficiencies are documented in the Fire Book supervised and actioned accordingly by the PIC
• Fire Safety Arrangements: Staff attend fire training annually. Recent Fire training was completed on: 26.03.2025 and 02.05.2025 and June 2025 .The PIC has coordinated staff attendance at Fire Training and Fire Drills to achieve compliance . 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 and May 2025
• Evacuation Proceedures: The fire evacuation drills have been implemeneted to ensure that all staff are confident and competent in all senarios and with different compartments .The Fire Safety Training officer has ensured that fire training, evacuation procedures and drill practices are realistic and that staff are confident and knowledgeable. Fire Drills will show evidence of Vertical and Horrizontal evacuation.The Fire Training Officer has implemeted all senarios into Fire training .The Fire training and Fire Slides will be reviewed and redesigned in 2025 to incorporate more drills and scenarios.
• Detecting or Containing Fires: The fire drawings will be updated to indicate the location of compartment boundaries and the Provider has instructed an Engineering company to complete this.
• A programme of works has commenced to upgrade fire rated ceilings, attic hatches and recessed ceiling lighting.
• Fire Detection: All Sluice room and store rooms are now fitted with Fire Detection devices.

• Containment Issue Fire Doors : Fire doors and glazing has been ordered and is in the eprocess of being replaced.
• Unsealed penetrations have been sealed or are in the process of being sealed.
• PEEPS: The PIC and Deputy have reviewed all residents "Personal Emergency Evacuation Plans ".All PEEPS now contain and state the type of evacuation best suited to the resident with reference to :equipment and method of evacuation ,mobility level and number of staff required.Any residents with additional or complex needs on the First Floor has been risk assessed by the PIC and moved to the ground floor level to reduce the risk .
• Fire Notices : Fire notices are under review .Additional Fire notices will be provided with accurate information in realtion to the centre .
• Fire Maps: The fire maps for the Centre will be available at the Fire Panel.The Current Fire Notices and Fire Action notices are under review .

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: The provider will review the two multi-occupancy rooms. The design and layout will be considered to meet the privacy and dignity of all residents.

Storage will be reviewed and additional storage provided.

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Red	17/03/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/05/2025
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	31/10/2025

Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	31/05/2025
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	31/05/2025
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	31/05/2025
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	Not Compliant	Orange	30/11/2025

	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	30/11/2025
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	30/11/2025
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	31/05/2025
Regulation 28(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 alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be	Substantially Compliant	Yellow	30/11/2025

	followed should the clothes of a resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	31/05/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	30/11/2025
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Red	30/11/2025
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	Not Compliant	Orange	31/07/2025

	the designated centre.			
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Yellow	29/04/2025
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	31/07/2025