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:	Saint Louis Nursing Home
Name of provider:	Yvonne Maher
Address of centre:	1-2 Clonmore, Ballymullen, Tralee, Kerry
Type of inspection:	Unannounced
Date of inspection:	15 October 2024
Centre ID:	OSV-0000289
Fieldwork ID:	MON-0044973

About the designated centre

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

St. Louis Nursing Home is a two-storey premises based in the town of Tralee and close to amenities such as shops, restaurants, and a library. While it is a two-storey building, all resident accommodation is on the ground floor. The centre provides 24-hour nursing and social care to 25 residents, both male and female, who are predominantly over the age of 65 years. The centre offers long and short-term care, respite and convalescence care. Bedroom accommodation comprises 15 single bedrooms and five twin bedrooms. Three of the single bedrooms are en suite with shower, toilet and wash hand basin. The aim of the nursing home, as set out in the statement of purpose, is to provide a high standard of professional care to residents in a safe and homely environment, while preserving and promoting independence.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	24

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 15 October 2024	10:00hrs to 18:10hrs	Niall Whelton	Lead

What residents told us and what inspectors observed

Saint Louis Nursing Home is located in Tralee town and is registered to accommodate 25 residents. The centre is within a three storey building, comprising two adjoined three storey terraced buildings to the front, with the majority of the nursing home in a single storey extended area to rear around a secure courtyard. The front three storey section has staff facilities and administration offices on the first and second floor with all resident accommodation located at ground floor. The main entrance to the centre is to the side and leads past a reception desk straight to the communal space with two corridors leading to bedrooms, each side of the courtyard. Residents' bedroom accommodation comprised 15 single bedrooms and five twin rooms. Three bedrooms had en suite toilet, shower and wash hand basin, while the remaining residents shared communal showers and toilets. The inspector saw one of the residents' bathroom was out of commission; there were upgrade works taking place in response to findings from the previous inspection. The provider decided to take the opportunity to renovate the bathroom also.

There is a separate detached building housing laundry facilities, maintenance and general storage.

The inspector was met by the provider and person in charge (PIC), who facilitated the inspection. This inspection included a focused review of the premises and fire precautions.

Overall, there was a homely feel to the centre; residents were up and about and had unrestricted access to the various communal spaces and secure courtyard garden. Staff were seen assisting residents in a patient and kind manner and did not hurry them, and were seen chatting with residents throughout the day. Visitors were observed coming into the centre throughout the day with no restrictions.

Communal space consists of a large sitting room to the front of the centre with views out to the street. There is a small visitors room for residents to use as a quiet space or to meet with visitors. The main dining room opens onto the secure courtyard and was nicely laid out.

The external space for residents was well maintained and had accessible pathways through gravel beds and planted areas. There was a number of garden benches for residents to rest and table and chairs for outdoor dining. The door to the outside had a lip at the door threshold which may restrict independent manoeuvrability through the door if using certain mobility aids or a wheelchair.

In some bathrooms and ensuites, there was more than one call bell cord. Some were decommissioned and not working when tested; these were from an older decommissioned system. The call bell in some ensuites did not work.

The inspector saw some areas where storage was poorly managed. The room at the bottom of the stairs had various items of storage. Hoists were being stored on bedroom corridors along with a cleaning trolley and some bins. These were relocated during the inspection.

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

Capacity and capability

This unannounced single day inspection was carried out to monitor compliance with the regulations made under the Health Act 2007 (as amended). The inspector also followed up on the progress made by the provider to address issues with the premises and fire precautions.

The systems of management in relation to fire safety and premises required review and improvement to ensure the service provided was safe and effectively monitored. Action had been taken by the provider to address the findings of the previous inspection, however oversight of fire safety management, identification of fire safety risks and the the upkeep of the premises required further action.

Immediate action was required during the inspection to address two fire safety risks; this is discussed under regulation 28, Fire Precautions.

Saint Louis Nursing Home is owned and operated by a sole trader, who works full time in the centre. The clinical management of the centre was led by the person in charge (PIC) who was supported by an assistant director of nursing, and a team of nursing, care, maintenance and kitchen staff. There had been a dedicated administrative staff member in the centre; this role was now vacant.

The provider confirmed that a fire safety risk assessment had been commissioned by a competent fire safety professional, who was due to visit the nursing home on 01 November. This assessment should identify, assess and risk rate potential fire safety risks in the centre to inform a time bound action plan to come into compliance with the regulations. Details of non-compliance of fire precautions is detailed under regulation 28.

Regulation 23: Governance and management

The management systems in place were not sufficiently robust to ensure the service provided is safe, appropriate, consistent and effectively monitored, for example:

- immediate action was required by the provider to address two fire safety risks, which had not been identified by the provider
- improvements were required by the provider in relation to oversight of fire safety management, identification of fire safety risks and the the upkeep of the premises.

Judgment: Not compliant

Quality and safety

This inspection found that there had been improvements in the quality and safety of the service, owing to actions taken with the upkeep of the centre and fire safety improvements. Notwithstanding those improvements, further action was required by the provider in the upkeep of the premises and the management of fire safety in line with regulation 17 premises and regulation 28 fire precautions.

In the main, the building appeared to be subdivided with construction that would restrict the spread of fire; however, deficits to fire doors, services penetrations through fire rated elements of construction, and poor fire containment to the upper floors meant that an assessment of fire containment measures in the centre was required to ensure adequate containment of fire.

The building was sub-divided into a number of fire compartments as identified to the inspector. Further assurance was required regarding the integrity of the fire compartments.

The fire doors to bedrooms were not fitted with a device to automatically close the door in the event of a fire. While there was a high level risk assessment, it was not robust to ensure that fire doors would be closed in the event of a fire. Staff spoken with did not reference closing fire doors when relaying the evacuation procedure, however they did know which doors remained open at night at the request of individual residents.

The provider and person in charge confirmed that ski-sheets (evacuation aid which fits beneath a mattress and is used to evacuate immobile residents) could fit out all exits, however there was no drill record to verify this.

Evacuation needs of residents were assessed through a personal emergency evacuation plan (PEEP). They were well laid out, contained sufficient and clear information and were easy to follow. Improvements were required in the review of the PEEPs as some required updating. This was attended to immediately.

The inspector observed a number of rooms which had extension cords in use; some with multiple plugs for various resident appliances and devices. Furthermore, there

was a badly damaged socket behind the bed of one resident. This required immediate action, which is detailed under regulation 28.

On previous inspections, there was excessive volumes of combustible storage in the second floor area, in areas that were not appropriately fire contained. On this inspection, the storage in these areas had been significantly reduced and was being managed. The window to a bathroom had been fixed and repair work was carried out to roof lights.

Regulation 17: Premises

Action was required by the provider to ensure compliance with regulation 17 and schedule 6;

- the call bell in some en-suites and a toilet did not work. In some en-suites there was pull cords from decommissioned call bell system in addition to the newer system resulting in confusion. The previous compliance plan committed to having unnecessary cords removed.
- the storage arrangements were not adequate. The area at the bottom of the stairs was used for storage; this was the only route of escape from the upper floors.
- there was continued use of extension cords. A review of electrical sockets is required to ensure there are sufficient sockets available for use by residents, to avoid reliance on extension cords
- there was a lip at the threshold to the door leading to the garden which was a potential trip hazard and may impede access where mobility equipment was used. This required review and risk assessment
- there were loose tiles to the encasement of the waste pipe in a bathroom; this could not be effectively cleaned
- the shelving unit within the treatment room was not secure
- there was no record to show the sluice machine had been serviced

Judgment: Substantially compliant

Regulation 28: Fire precautions

The inspector was not assured that the registered provider had taken all reasonable actions to ensure that residents were appropriately protected from the risk of fire. Under this regulation, immediate action was required by the provider to address urgent risks;

- in one bedroom, the inspector observed a badly damaged electrical socket, with wires exposed; this occurred from the bed frame impacting the socket over time and created a risk of fire
- there was inappropriate combustible storage within the electrical room, increasing the risk of fire.

The manner in which the provider responded to the risks did provide assurance that the risks were adequately addressed. The provider contacted an electrician who came during the inspection and replaced the socket and the electrical room was cleared out during the inspection.

Improvements were required by the provider to ensure adequate precautions against the risk of fire, reviewing fire precautions, and ensuring fire prevention practices were adhered to, for example:

- the process for the identification and management of fire safety risks was not adequate
- during meal times, the door to the kitchen, which is a room of increased fire risk, was propped open with a hook to the wall; this practice would allow the uncontrolled spread of fire. Where fire doors are required to be held open, they should be connected to an appropriate hold open device, which is connected to the fire detection and alarm system and will release when the fire alarm is activated
- there was continued use of extension cords, some of which were placed in a manner that was not safe, for example on a bedside locker with combustible items
- as referenced above, owing to sockets located behind beds, there was no system in place to ensure they would not be damaged from the impact of moving the bed
- hoist batteries were being charged within an escape corridor, introducing a risk of fire to the escape route
- bedroom doors were not fitted with automatic closing devices. While there was a risk assessment in place, it did not include that staff were required to close the fire doors during evacuation.

Action was required to ensure adequate containment and detection of fire, for example;

- fire doors to rooms other than bedroom doors were not fitted with automatic closing devices and were found to be open, for example the large day room. Where doors are required to be held open, they should be fitted with a suitable automatic door closer and device to release the door upon activation of the fire detection and alarm system
- the fire containment measures in the first and second floor of the building were not adequate. There was only one means of escape for staff from these levels and the escape route was not adequately protected from adjacent risk rooms, such as store rooms and offices. In particular, there was a hole in the wall between the nurse supply store beneath the stairs and the stairs enclosure

- service penetrations were noted in construction providing a barrier to fire, these required sealing up
- some fire doors were not fitted with smoke seals to prevent the spread of smoke.

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

- the provision of exit signage was not adequate. In a number of area in the centre, exit signage was not visible. The directional arrow to an exit sign directed escape into a bedroom and not the exit
- hoists and a cleaning trolley stored on the corridor partially obstructed the escape route; these were moved during the inspection to an appropriate location
- the provision of emergency lighting along some external escape routes was not adequate.

The arrangements in place for maintaining fire equipment, means of escape, building fabric and building services were not adequate, for example

- some adjustments were required to fire doors to ensure they could close. The hinges to some fire doors were missing screws. The heat and smoke seals were missing to the edge of some doors and required replacement
- there was no record of a periodic inspection report for the fixed wire electrical installation. Considering the damaged sockets and reliance on extension cords, this is required to ensure the electrics in the building are safe.

The measures in place to safely evacuate residents and the drill practices in the centre required action

- the inspector observed some beds, where the ski sheet was not correctly fitted to the bed. This may cause delays if required to assist the resident to evacuate. This was addressed on the day of inspection
- from a review of drill reports, there was insufficient detail to show that resources available were sufficient to ensure the safe evacuation of a fire compartment
- there was no evidence in evacuation drill reports to demonstrate and verify that all evacuation aids would fit through all exits, and along subsequent external escape routes; the exit near bedroom 7 was particularly tight
- staff knowledge was mixed regarding the evacuation procedure and requires strengthening to ensure all staff are fully aware of the evacuation procedure.

Further assurance was required in relation to fire safety training. With the absence of an administrative staff member, the training matrix was not up-to-date. The inspector was told that staff had received training.

The procedures to follow in the event of a fire were not prominently displayed in the centre.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

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

Compliance Plan for Saint Louis Nursing Home OSV-0000289

Inspection ID: MON-0044973

Date of inspection: 15/10/2024

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: Since our inspection on 15th October 2024 1.Management have set up a maintenance recording book. Staff record any defects/broken/damaged/replacements required items in this book by date, job required, date of completion and signatures. When the job is completed by the Maintenance man it will be signed off in the book. 2.Management will commence regular walk arounds in the home to ensure everything is in good working order and any defects will be recorded in the Maintenance Book for repair by the Maintenance Team. Management liase with maintenance to ensure all defects are repaired/replaced in a timely manner. The walk-abouts will be recorded at least twice weekly and available for inspection. 3.Management have employed a Maintenance Man who works 3 full days in the N.H.and ensures any jobs outstanding are resolved during his duty. He will also attend when requested should an urgent matter occur which must be resolved immediately. 4.Management have agreed an annual Fire Audit and Review of Fire Management at St. Louis to ensure a safe environment is maintained for all our Residents. As a result of the combined action plans listed above Management is confident Fire safety, risks and identification will be much improved in the Home.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: As outlined above, we are confident the regular walk-arounds in the home and the recruiting of a Maintenance Man as part of our permanent work force will identify any defects and resolved within a timely framework. On going improvements in the home will	

continue and some defects identified on Inspection on 15th October 2024 have since been resolved. For example storage areas on corridors and bottom of the stairwell have been cleared to allow unimpeded pathways to exit doors.
Decommissioned Call bells have been removed from toilets/bathrooms to reduce confusion.
Shelving in the Nurse/Treatment room has been repaired.
Loose tiles to the encasement of waste pipes in bathroom adjacent to room ten have been replaced and are now secure.
Escape Ladder will be sourced for clerical/storage rooms on 2nd and 3rd floor of the home which will ensure staff on these floors can vacate the building in the event of a fire. This ladder will be purchased and installed. This will also include the installation of a new window with suitable opening to allow evacuation by ladder. (It is also intended to install fire doors at the bottom of the stairs to delay the spread of fire and allow staff on 2nd and 3rd floors time to exit the building).
Following our Hard wiring Inspection, the Electrician and Management have devised a plan and acceptable time frame for completion. We are hopeful all work will be completed within this time frame. Included in the plan is installation of additional sockets where required to reduce overdependence on extensions leads in the Home.
The sockets will be protected by 'Bumpers' which will be installed to protect them from damage from bed frames/wheels as they are pushed from A to B during normal day activities in the home.
In the dining room a 'ramp' will be installed on either side of the new double doors to the garden to ensure safe entry and exit and to reduce the risk of slips, trips and falls in the home. This should be completed shortly.
Management have contacted company who supplied our Sluice Machine and they have set up an annual inspection report/service contract.
Toilet/shower at bottom of corridor (near room 9) has been replumbed/retiled and redecorated and ready for use. (this was out of order during inspection).
There is ongoing redecoration and repainting in the Home all year round to ensure pleasant environment for our Residents.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: 1. Audit and Review of Fire Management completed. 2. Hard Wiring report completed and plan devised between Care Provider and Electrician. Phase one of installation and repositioning of electrical sockets has been completed. This will eliminate the need for extension leads and that the location of sockets are ergonomically friendly for Residents and Staff. They are also positioned to eliminate the risk of damage. 3.Automatic release system will be installed to kitchen door and double doors into Day room to ensure automatic closure and fire containment in the event of a fire. All other fire doors to all fire risk room (other than bedrooms) have been reviewed to ensure they are fitted with suitable automatic door closing devices. Phase one of automatic closing devices for bedroom doors will be installed along with automatic release systems to kitchen and day

room. 4. Hoist battery charged in back hall away from Resident's corridors. The charging port is mounted on the wall and poses no obstruction in the back hallway. It will not impede evacuation of first and second floor in the event of a fire. Evacuation from first and second floors of the N.H. will be via a new fire escape window which has been measured and ordered for first floor window. A fire escape ladder has been purchased to facilitate exit from this new window. A new fire door has been installed at the bottom of the stair way. Fire containment measures in the first and second floors of the N.H. have been secured and sealed. Fire seals to all fire doors are present and intact. Additional Exit signs with arrows indicating escape routes will be installed in the N.H. and external lighting will be installed to facilitate safety during evacuation in the event of a fire. Ski sheets underneath the mattresses will be checked daily to ensure they are positioned correctly and belts neatly tucked underneath to allow swift access and swift exit from the building.6. Peeps will be periodically updated to ensure all information is correct. PIC will ensure this is done every 4 months or sooner if the condition of a Resident deteriorates/changes. 7. Since inspection 15th October 2024, All Staff have received fire training on 25th November 2024. This fire training was centre specific. 8.Fire drills will her held monthly and staff in attendance will sign. Fire drill reports will be detailed providing information on fire training/drill delivered/compartment evacuation/routes exited/time frames achieved/staff in attendance. 9. Regular Informal discussions between Staff on a daily basis identifying Fire Wardens and reminders of fire drill in the event of a fire. These discussions take place after handovers in the morning time when all Staff are present. 10.Fire Evacuation procedures will be displayed throughout the N.H.. 11.List of employees who live close by and who can attend the N.H.. to provide assistance in the event of a fire or evacuation of the building will be displayed along-side the Fire Evacuation Plan. 12.Fire doors including door screws/seals/have been checked and completed. 13. All combustible material will be disposed of and not stored in the N.H. reducing the risk of fire. 14.Gaps/holes identified in the masonry will be filled in to reduce the spread of fire/smoke in N.H.

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	22/02/2025
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	30/01/2025
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment,	Not Compliant	Orange	22/02/2025

	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	30/03/2025
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	30/03/2025
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/01/2025
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	01/03/2025
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	30/01/2025

	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(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	30/01/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/01/2025
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.	Substantially Compliant	Yellow	30/01/2025
Regulation 28(3)	The person in charge shall	Not Compliant	Orange	30/01/2025

	ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.			