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:	Ashbury Private Nursing Home
Name of provider:	A N H Healthcare Limited
Address of centre:	1A Kill Lane, Kill O'The Grange, Blackrock, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	21 July 2023
Centre ID:	OSV-0000007
Fieldwork ID:	MON-0041121

About the designated centre

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

Ashbury Private Nursing Home is located in Blackrock, Co Dublin. The nursing home is serviced by nearby restaurants, public houses, libraries and community centres. The nursing home comprises of the main house and an extension called the grange wing. The nursing home is registered to provide 97 bed spaces with 51 beds located in the main house and 46 beds available in the grange wing. There is a range of communal areas inside for residents to enjoy and two gardens for residents use.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	91

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Friday 21 July 2023	09:00hrs to 17:00hrs	Siobhan Nunn	Lead
Friday 21 July 2023	09:00hrs to 17:00hrs	Noel Sheehan	Support

What residents told us and what inspectors observed

This was an inspection following an incident in which a resident was severely injured as a result of burns sustained in Ashbury Nursing Home on the 28 June 2023. As required by regulation 31 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), the person in charge of Ashbury Nursing Home has given notice to the Chief Inspector of a serious injury to a resident on 24 June 2023. The information received related to the injury of a resident as a result of severe burns sustained while the resident was smoking in Ashbury Nursing Home. Initial contacts had been made by inspectors prior to this inspection to ascertain more detailed information regarding the event, risk management procedures and particulars of the injured resident.

The inspection took place in Ashbury Nursing Home over the course of a day. Inspectors observed that there was a pleasant and relaxed atmosphere in the designated centre. Residents and visitors who spoke with inspectors described their satisfaction with the care provided in the designated centre.

On arrival inspectors met with the Director of Nursing and viewed the smoking room and garden area downstairs before viewing other areas in the designated centre.The centre consists of two units. An original period building known as the Main House and a newer wing known as the Grange Wing. A link corridor joined the two units and had comfortable seating looking out on the garden. The area was brightly decorated with books and a small canary in a cage, on a side table to entertain residents.The centre comprised of a mixture of single, twin, triple and four-bedded bedrooms. In the main house there were 16 single bedrooms, 13 of which had en-suite facilities; eight twin bedrooms, three of which had en-suite facilities; three triple occupancy bedrooms, one with en-suite and three four-bedded bedrooms, one of which had en-suite facilities. In the Grange Wing there was 28 single bedrooms, 21 of which had en-suite facilities and nine twin bedrooms three of which had en-suite facilities. In both buildings there were lifts and stairs to facilitate movement between the floors and there were wall mounted handrails throughout to support and facilitate residents' independence and mobility.

The activities programme was well advertised throughout the building with pictures and brightly coloured notices in the hallways and communal areas to inform residents of upcoming events. Throughout the day residents informed inspectors that they were happy with the care they received. One resident described how they "enjoyed the food in the centre" and another resident said that the "meals are very nice and the staff are lovely".

Inspectors observed that areas of the flooring in the day space on the Grange Wing were damaged following an external accident on the road that damaged the floor, window and surrounding brickwork.

The main access to the smoking room was through a glazed door opening onto the

corridor between the day space and the nurses station in the Grange wing. The smoking room is located adjacent to a nurses station and is mostly visible directly from that area.The smoking room is serviced by both natural and mechanical ventilation. On entering the room a fully glazed sliding door was located to the left and gave access to a small garden used for smoking. Further along the corridor another glazed door provided a second access point to the small garden. Inspectors observed cigarette butts on the ground and in the flower bed in the garden. A small bucket filled with water, was located on the ground was used as an ashtray for this area. On entering the smoking room inspectors found that a fire blanket was mounted on the left wall of the room. A television was mounted beside the fire blanket in the corner. A fire extinguisher was also present. Inspectors were informed that the television was not in use. Five smoking aprons hung on hooks on the right hand wall with personal alarms on lanyards hanging beside the aprons. A smoke detector was mounted on the ceiling. Tiles covered the floor of the smoking room and a large bucket filled with water was used as an ashtray. There were three chairs for residents use in the room. Inspectors observed cigarette butts on the paved area outside and in the shrubbery, and cigarette ash on the floor in the smoking room. One chair in the smoking room had a round hole resembling a burn mark on the upholstery.

On the day of inspection inspectors observed that the smoking room was used by residents throughout the day and once finished their cigarette they would return to the day room. The premises has been installed with an extensive CCTV system.

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 ad safety of the service being delivered.

Capacity and capability

This was an unannounced inspection. Inspectors spoke with the provider, the person in charge and a number of staff. A detailed inspection of the smoking room was carried out. Documents which included risk management policies, safety statement, care plans, the accident and incident log, complaints log and medical administration records were also reviewed. The provider is closely involved in the running of the centre and is present there on a regular basis. The person in charge is employed on a full-time basis and is involved in the day-to-day running of the centre. All management and staff spoken to expressed a commitment to making every effort to support the safety and welfare of residents.

The person in charge is employed on a full-time basis and is involved in the day-to-day running of the centre. All staff spoken with were committed to improving the service to residents and all expressed regret at the incident that had occurred. Risk management information with specific regard to the injured resident and other smokers showed that individual risk assessment were in place, and control measures

put in place took into account residents' cognitive and physical impairments and their respective will and preferences. Staff spoken with, and documentation and record keeping seen by inspectors, demonstrated that at the time of the incident the supervision provided was appropriate to residents' assessed needs based on the information available at the time of admission and subsequent reassessment.

ANH Healthcare Limited is the registered provider for Ashbury Private Nursing Home. There was an established and clearly defined management structure in place that identified lines of authority and accountability. The person in charge was present in the centre on a daily basis Monday to Friday. There was also a director of nursing, who worked alongside the person in charge to support her in her role. A schedule of clinical and environmental audits evaluated key areas such as responsive behaviour, falls, staff files and medication management. The quality of care was monitored through the collection of weekly data, such as monitoring the MUST scores, use of bedrails, medications and the incidence of wounds and falls. However inspectors found on the day of inspection that the systems for the oversight of the safety of the smoking area were not sufficiently robust to ensure that residents were safe at all times. There were systems in place to monitor the quality and safety of the service.

Risk assessment and management information regarding smoking in the centre was available within the following documentation given to inspectors:

- the site-specific health and safety statement and risk assessment for the centre
- the fire safety register that referred to the overall safety of residents and staff in the centre
- other policies and procedures which specifically addressed residents' safety issues such as care of residents with dementia, wound care management and responding to challenging behaviour, organisational risk assessments,
- management of internal emergencies including missing persons and fire evacuation, and
- individual residents' care plans that referred to individual risks.

At the time of the incident the health and safety statement had identified the smoking room as the designated smoking area for residents and was the only area of the centre where smoking was permitted. Staff, residents and visitors were not permitted to smoke within the nursing home. Inspectors viewed a "Draft Incident Analysis Report" prepared by the person in charge which provided details of the formal internal investigation which commenced on the 26th June 2023. In summary a review had occurred and improved practices were identified for implementation.

An incident report was completed by the clinical nurse manager on duty on the 23 June 2023, detailing the fire and the actions of staff who responded immediately. The provider and person in charge promoted a culture of health and safety of residents. Inspectors saw that following the incident managers communicated with staff and provided information about available support services including counselling. Family members were contacted and provided with information and support. All residents who could understand the incident were informed and

managers phoned the families of all residents to explain what happened.

Following the incident, management took the following actions:

- An external investigator was appointed to conduct a review of the incident that included in depth interviews with staff.
- The wearing of a smoking apron was made mandatory for residents while smoking
- Residents were also required to wear a call bell around their neck while smoking
- The cigarette lighter on the wall was removed
- Larger fire blankets were ordered
- Enhanced supervision of residents in the smoking area.

Inspectors were informed that these were not long term measures, but that residents were happy to comply with these additional safety measures. Inspectors spoke to a resident who said that they were happy to wear the apron and call bell for their safety. However on the day of the inspection the actions had not been fully implemented. Inspectors observed inappropriate wearing of aprons, absence of call bells worn by residents, and insufficient means of disposing of butts and ash. In addition, the monitoring of the smoking area as seen by the Inspectors needed to be more frequent. An urgent compliance plan was issued following the inspection regarding smoking safety.

The registered provider ensured that there were sufficient staff on duty to provide care to residents. Between 8am and 8pm there were 2 staff nurses and 12 health care assistants in the Grange wing and two staff nurses and eleven health care assistants in the Main House. At night there were two staff nurses and six health care assistants on duty covering both units. Staff records were made available for inspectors to review.

Inspectors were provided with records of staff training including fire safety, manual handling, safeguarding, and infection prevention and control. All records showed a high level of attendance with ongoing training planned for the future. An up to date "Staff Induction, Orientation and Supervision" policy was available to guide managers. "Staff Fire Information Handbooks" for each unit were made available to staff on orientation as well as in leaflet holders on the units. Staff training manuals viewed by inspectors contained a section on fire and emergency response.

There was a major incident emergency plan in place, in the event of serious disruption to essential services. The centre's risk register was well maintained with environmental and clinical risks identified and assessed, and measures and actions in place to control the risks. Inspectors viewed a copy of the "Local Area Nursing Homes Emergency Evacuation Response Plan -2023" of which the nursing home is a participant.

A feedback meeting was held between the inspectors and the person in charge at the end of inspection. At the feedback meeting a discussion place took regarding achieving a balance between a resident’s choice to smoke and ensuring reasonably

practicable fire safety management practices.

Regulation 15: Staffing

There was an appropriate number and skill mix of staff in the designated centre to meet the assessed needs of residents on the day of inspection.

Judgment: Compliant

Regulation 16: Training and staff development

A comprehensive induction programme was in place which included fire safety awareness. 93% of staff were up to date with their fire training on the day of inspection with training planned for August 2023. Managers ensured that staff were made aware of fire safety precautions through induction, annual fire training, weekly fire drills and the provision of the "Staff Fire Information Handbook"

Judgment: Compliant

Regulation 21: Records

Inspectors reviewed the records of five staff and found that information required for compliance with Schedule 2 was contained in the files. This included staff identification documents, details of Garda vetting and references.

Judgment: Compliant

Regulation 23: Governance and management

Management systems required action to ensure effective oversight of the quality and safety of service delivered to residents.

- Systems for the monitoring of residents in the smoking room and garden did not identify the risks related to poor fire safety practices as identified under Regulation 28 Fire precaution. The learning from the recent incident did not identify the requirement for more frequent monitoring of the smoking area. An urgent compliance plan was issued following the inspection regarding smoking safety.

- While the registered provider had taken enhanced actions to protect residents who smoke following the recent tragic incident, there was a lack of oversight to ensure that these measures were fully implemented.
- The provider had not ensured compliance with Condition 4: "By no later than the 15 June 2023 twin bedrooms 310/311, 318/319, 320/321 and quadruple bedroom 322/323/324/325 in the designated centre will be renovated and reconfigured or the number of residents accommodated in them will be reduced to achieve compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013."
- A number of risk assessments reviewed by inspectors were in response to COVID-19 and referred to out of date Public Health guidance.

Judgment: Not compliant

Regulation 31: Notification of incidents

The Chief Inspector was notified as set out in Schedule 4 of the Health Act 2007 (Care and welfare of residents in designated centres for older people) Regulations 2013.

Judgment: Compliant

Regulation 34: Complaints procedure

A complaints procedure was in place and this was displayed prominently in the centre. The record of complaints was reviewed by the inspectors. These records identified that complaints were recorded and investigated in a timely way and that complainants were advised of the outcome of their complaint. A record of the complainant's satisfaction with how the complaint had been managed was also documented.

Judgment: Compliant

Regulation 4: Written policies and procedures

Up to date written policies and procedures were in place in accordance with Schedule 5.

Judgment: Compliant

Quality and safety

Overall residents received a good standard of care.

A fire safety register was available in which there was evidence of fire drills being conducted on a weekly basis. Frequent and up-to-date checks were documented on the maintenance of fire safety equipment (monthly and annual), emergency lighting testing and maintenance (quarterly), means of escape kept clear (daily) fire alarm tests (weekly), fire resisting and exit doors (weekly) and periodic testing and maintenance of fire extinguishers by a contractor. The policy on fire was comprehensive and detailed the location of fire escape exits, break glass units, fire blankets, fire extinguishers, fire zones and the fire panel. This policy also detailed the actions to be taken in the event of a fire.

Personal Emergency Evacuation Plans were prepared for residents and documented in a handover sheet which detailed resident's medical needs, dependency levels and the level of assistance required in the event of evacuation. The level of assistance was colour coded on the sheet with green signifying minimal assistance, yellow requiring assistance of one, red requiring assistance of two and purple indicating that the resident had responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Inspectors observed colour coded stickers over residents' beds to guide staff in the event of an emergency.

Inspectors viewed smoking risk assessments for five of the six residents who smoked in the designated centre. The sixth resident, who was a newly admitted resident for respite, told inspectors that they had been assessed and the control measures had been discussed with them were happy to wear and the smoking apron for their own safety. Varying individualised risk controls are identified in the care plans of other residents who smoke. Some smokers hold onto their own cigarettes. It was identified in the care plans and by staff that some residents require more observation than others.

The smoking room contained one large bucket of water to act as an ashtray and the small paved smoking garden area outside contained a smaller bucket which also acted as an ashtray. They were located on the ground and inspectors observed that they were not easily accessible to residents resulting in cigarette butts and ash being on the ground in the garden. There were signs displayed in the smoking room informing residents that it was mandatory to wear a smoking apron and call bell.There is a maintenance log in place that details issues, date and time reported and location. On the logs reviewed by inspectors, no issues regarding the smoking room were recorded.

Currently the centre has an attached Condition 4:" By no later than the 15 June 2023 twin bedrooms 310/311, 318/319, 320/321 and quadruple bedroom 322/323/324/325 in the designated centre will be renovated and reconfigured or the

number of residents accommodated in them will be reduced to achieve compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013". A number of curtain rails had been reconfigured in bedrooms including room 322/323/324/325 where rails had been re-positioned to provide privacy for residents and new wardrobes with integrated bedside lockers had been installed. However the work completed on reconfiguration had not resulted in sufficient privacy for residents in room 310/311 and room 318/319 as there was insufficient room for a chair and a limited area beside one bed for a resident to carry out personal activities in private in room 310/311 and insufficient room to manoeuvre equipment and ensure privacy in room 318/319." The registered provider had completed a number of actions outlined in their compliance plan from the previous inspection. The flooring and table surfaces in the dining room in the Main Building had been replaced.

A variety of activities were available to residents including outings. Residents' views were obtained through monthly resident committee meetings along with a recent satisfaction survey which was incorporated into the centre's annual report on the quality and safety of services delivered to residents. Residents were provided with a variety of recreational opportunities and residents had access to television, radio and magazines. Arrangements for accessing an advocacy service were displayed in the centre.

Regulation 17: Premises

The following issues were identified by the inspectors that require attention:

- Privacy curtains in some multi-occupancy bedrooms required reconfiguration as not all bed spaces within privacy curtains were large enough to contain a bed, chair and storage space. For example, the curtain track in room 318/319 had been repositioned however there was insufficient space to manoeuvre a hoist without entering the second residents' private space. Staff explained that they try to use the hoist when the second resident is not in the room. The curtain rails in room 310/311 had been reconfigured, however there was insufficient room for a chair and personal storage space for one resident. This impacted on residents' right to privacy when assessing their possessions or clothes or to just sit and have some quiet time at their bedside in privacy.
- Room 320/321 had not been reconfigured. It remains registered as a double room and was in use as a single room on the day of inspection.

Judgment: Not compliant

Regulation 26: Risk management

There was a risk management policy in place detailing the five specified risks outlined within the regulation.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had taken actions to address compliance with fire safety precautions since the previous inspection in December 2022, however the following issues required attention:

- Fire exit routes were not clear due to equipment being stored on the landings in the Main House.
- Fire drills records had been improved since the previous inspection and provided specific recommendations for ongoing improvement. Fire drills were carried out on a weekly basis however it was identified by inspectors that the fire drills in the Main House for 2023 were repetitive and the scenarios needed to be varied.
- The fire door located adjacent to Room 317 was not closing fully on release.

Issues specific to the protection of residents who smoke required attention:

- Systems for the monitoring of residents in the smoking room and garden did not identify the risks related to poor fire safety practices including, inappropriate wearing of aprons, absence of call bells worn by residents, the presence of burn marks on a chair in the smoking room and insufficient means of disposing of butts and ash. The learning from the recent incident did not identify the requirement for more frequent monitoring of the smoking area. Risk assessments of residents identified the requirement for monitoring but not the frequency. An urgent compliance plan was issued following the inspection regarding smoking safety.
- While the registered provider had taken enhanced actions to protect residents who smoke following the recent tragic incident, there was a lack of oversight to ensure that these measures were fully implemented. For example, Inspectors observed two residents in the smoking room separately. One resident was not wearing a call bell and the smoking apron was tied incorrectly, which resulted in the apron providing limited cover to their upper body and not acting as a means of fire prevention. Staff had put on the apron and lit the residents cigarette. They were flicking their ash on the floor as they could not reach the bucket of water used as an ashtray, which was placed on the other side of the room. Inspectors observed a second resident being assisted by staff. When the staff left the smoking area they were not wearing a call bell and their apron was put on incorrectly.This resulted in the resident having insufficient upper body protection to prevent fire and no way to call for assistance.

Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk. The provider's response provided assurance that the risk was adequately addressed.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Resident care plans were seen to be detailed and person-centred, and were informed by an assessment of clinical, personal and social needs. A comprehensive pre-admission assessment was completed prior to the resident's admission to ensure the centre could meet the residents' needs. A range of validated assessment tools were used to inform the residents care plans. Care plans were formally reviewed at intervals not exceeding four months. Where there had been changes within the residents' care needs, reviews were completed to evidence the most up to date changes.

Judgment: Compliant

Regulation 9: Residents' rights

The layout and configuration of multi-occupancy bedrooms required attention to ensure that residents' right to privacy and dignity were supported. Privacy curtains in room 318/319 did not allow sufficient space for a resident to receive care.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Ashbury Private Nursing Home OSV-0000007

Inspection ID: MON-0041121

Date of inspection: 21/07/2023

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: Currently we have implemented a 10 minute check for residents who are smoking. Aside from the existing call bell present in the smoking room, individual call bells were attached to each smoking apron. Stainless steel tables and chairs were immediately put in place. Staff received additional training in relation to the placement of the smoking aprons on residents. While we would very much like to continue to support our residents to exercise their choice in respect of smoking, after much deliberation, we have taken the decision to close the smoking room by the end of 2023 because we cannot fully eradicate the risks associated with smoking. Multi occupancy bedrooms referenced in report, were renovated and reconfigured. Please see photographic evidence attached.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Multi occupancy bedrooms referenced in report, were renovated and reconfigured in	

accordance with our previous action plan, prior to this inspection.
Please see photographic evidence attached.

As per the factual inaccuracy form, the layout of room 318 / 319 supports the privacy and dignity of both residents while receiving care.

Room 310 / 311 has the capacity to provide for a chair and personal storage space for both residents.

Reference to room 320 / 321, the lady occupying this room has been granted use of it as a single, until such time as she departs us, after which we will reconfigure the room to revert as a double. It would be inappropriate to do so before she departs.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Reference to fire exits. The "equipment" referred to, is in use during morning care, and is removed once all residents have been attended to. The linen trolleys in question are light weight wheel based and are easily moved in the event of fire. Notwithstanding that, there is sufficient space for full use of the fire exit route. The items are documented in our risk register and are considered low risk.

The fire drills in the main house have been upgraded with new scenarios to ensure variances in the fire drills. These are signed off by the DON.

Results of the weekly fire door checks are communicated to management as well as maintenance to ensure that all issues are actioned immediately.

We implemented with immediate effect the following temporary measures: Stainless steel tables and chairs in the smoking area, additional floor-based ash trays as well as table-based ash trays, individualized call bells attached to each individual smoking apron and the mandatory wearing of smoking aprons as well as 10 minute monitoring checklist and staff sign off sheet and retraining of all staff on the correct application of a smoking aprons.

While we would very much like to continue to support our residents to exercise their choice in respect of smoking, after much deliberation, we have taken the decision to close the smoking room by the end of 2023 because the monitoring required to fully eradicate all risk is impossible to achieve in the current context of nursing home care.

Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: We have submitted photographic evidence that the required adjustments to privacy space in the particular bedrooms noted in the report occurred in June of 2023 as per our previous compliance plan.	

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.	Not Compliant	Orange	04/10/2023
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	04/10/2023
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	04/10/2023

	suitable building services, and suitable bedding and furnishings.			
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	04/10/2023
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	31/12/2023
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 followed should the clothes of a resident catch fire.	Not Compliant	Orange	04/10/2023
Regulation 9(3)(b)	A registered provider shall, in so far as is	Substantially Compliant	Yellow	04/10/2023

	reasonably practical, ensure that a resident may undertake personal activities in private.			