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:	04 October 2021
Centre ID:	OSV-0000007
Fieldwork ID:	MON-0034389

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 99 bed spaces with 53 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:	83

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
Monday 4 October 2021	09:05hrs to 18:45hrs	Niamh Moore	Lead
Monday 4 October 2021	09:05hrs to 18:45hrs	Margaret Keaveney	Support

What residents told us and what inspectors observed

From what residents told us and from what inspectors observed, most residents were happy with the care and services that they received within Ashbury Private Nursing Home. Inspectors observed that there was a relaxed and happy atmosphere within the centre and that residents were at ease in the company of staff, with many positive interactions seen. While residents reported to be content, inspectors noted improvements were required in a number of areas which will be discussed further under their relevant regulations.

On arrival at the centre, inspectors were guided by the receptionist through many of the infection prevention and control measures necessary on entering the designated centre. This included a signing-in process, checking for signs of COVID-19, hand hygiene and the wearing of face masks. Inspectors were told that temperature checking is also part of the entry process for all visitors to the centre.

Inspectors were provided with a tour of the premises by two members of the management team. Following this tour, a short opening meeting was completed with a provider representative, the person in charge and an assistant director of nursing.

This designated centre comprises of two units referred to as the Main House and the Grange Wing. Both units are linked by a corridor that is set out with comfortable seating and books along a window sill for residents to enjoy. Corridors within the centre were wide and fitted with handrails which assisted residents to freely move throughout, however inspectors noted some handrails were not easily accessible due to storage in corridors. There was a variety of communal areas available to residents, however inspectors found that on the day of inspection, the day room in the Grange Wing could not be accessed by residents as it was being used to store residents' equipment. Inspectors observed that the centre had fish tanks which provided a nice homely environment within these communal areas. There was a small garden available to residents, which was well maintained.

The Grange Wing is a newer extension to the Main House. It was set across two floors with residents' bedrooms on both the ground and first floors. Residents of the Grange Wing were accommodated in single and twin bedrooms. The Main House was across three floors with residents' bedrooms on all floors, which comprised of single, twin, 3-bedded and 4-bedded rooms. Residents had access to an en-suite or to shared bathrooms.

Bedrooms were pleasantly decorated with a secure locked space for each residents' possessions available. Residents were also provided with their own personal wardrobe space. The general feedback from most residents, but not all, was one of satisfaction with their bedrooms, with one resident commenting that the wardrobe space was "too small" to store their clothing. Inspectors also found that in some multi-occupancy rooms that the private space was limited. Residents, in such rooms,

were provided with a bed and a bedside locker within their privacy curtain. However due to the limited space their wardrobe or a bedside chair was not placed within this area. This will be further discussed within this report.

Inspectors spent time observing staff and resident interactions and found that staff were seen to care for residents in a professional and friendly manner. It was clear that staff knew the residents well, and respected their preferences with one resident being provided with their favourite snack daily. Inspectors also spoke to seven residents throughout the on-site inspection and all unanimously commented positively on the staff within the centre, with comments that the staff team were "very kind and helpful", "friendly" and "terrific". Feedback from residents was that they felt happy and safe living in the centre, reporting that it was "home from home" and "I have everything I need".

On the day of inspection, residents from the Grange Wing were restricting their movements due to a suspected COVID-19 case. In addition visiting to this unit was suspended and inspectors were informed that all families had received correspondence on this. Usually, visits to the centre were by appointment, through an online booking system and limited to 30 minutes each. Visits were facilitated in two spacious cabins that were located in the centres' car park. The cabins were comfortably furnished and decorated, and fitted with movable Perspex screens, hand sanitisers and personal protective equipment (PPE) to protect residents and visitors from the spread of infection during visits. While inspectors were informed that indoor compassionate visits were accommodated, it was noted from recent residents' meeting minutes that some residents were not satisfied with the length of visits and unavailability of indoor visits to all residents. In addition, feedback from families dated June 2021 had similar findings.

Activities on offer were displayed on notice boards. There was a wide variety of activities being provided to residents which included flower arranging, quizzes, crosswords and mass. Art and exercise activities were taking place on the day of inspection. Inspectors observed that a resident had their nails painted, as part of a beauty therapy activity. Residents spoken with said that there were sufficient activities on offer, and they could choose to participate in them. Residents had enjoyed a summer party in the garden with live music, which they reported was a fun and memorable occasion. Inspectors were also informed that eight residents had been on an outing to Belfast the week before the inspection and that they had enjoyed the trip. One resident said that these trips were a "blessing" after the pandemic restrictions.

Inspectors observed the mealtime experience in both units on the day of inspection. The dining areas were bright and clean, and the food was seen to be well presented. The daily menu was displayed on a board within the dining room to assist residents with their meal choices, with a choice offered for the main meal. The mealtime experience was seen to be a relaxed and social occasion with residents talking amongst themselves and staff providing help to residents' in a sensitive and discreet manner. Residents spoken with said they enjoyed the food on offer. In addition, inspectors observed drinks were readily available throughout communal

areas

Overall, the centre was clean and well-maintained, however wear and tear was visible in some areas which did not always support effective cleaning and appropriate disinfection. The provider informed inspectors that there were plans to upgrade worn flooring and carpeting seen in some areas of the centre. In addition, inspectors found that there was limited storage space within the centre which impacted on residents accessing bathrooms, communal areas and some of the hand-rails in hallways. Inappropriate storage was also seen at fire exits which included boxes and items of furniture, and oxygen cylinders were being stored insecurely at a door. Inspectors were informed that this exit was not part of the centres evacuation plan, however there was signage on the door that indicated it was a fire exit. This will be further discussed within this report.

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

While there were established management structures in this centre, inspectors found that improvements were required in the management systems for the effective oversight of restrictive practices, visiting arrangements, premises, infection control and fire precautions.

A N H Healthcare Limited is the registered provider for Ashbury Private Nursing Home. One of the company directors represented the provider. The management structure was clear with the management team consisting of the provider, the person in charge and a general manager.

The person in charge was supported in their role by an assistant director of nursing (ADON), three CNMs, nurses, care managers, healthcare assistants, activity coordinators, housekeeping, catering, maintenance and administrative staff.

Inspectors reviewed the worked and planned roster and were assured that there was sufficient staff to meet the assessed needs of residents. Staff were organised into two separate teams to cover the Grange Wing and the Main House. Rosters showed there was a minimum of one registered nurse on duty at all times in both areas of the centre, in line with regulatory requirements.

Staff were supported to access mandatory training. Records reviewed showed that there was high attendance at mandatory training on safeguarding, manual handling and COVID-19. The provider had identified that refresher fire training was overdue for 37% of staff. The person in charge informed inspectors that dates for further fire safety training had been scheduled. Evidence was seen that these training sessions

were scheduled on a weekly basis, for the weeks following the inspection.

The provider had a policy on Staff Education and Training which had been issued in October 2019. The provider had recently reviewed performance management within the centre which included performance review meetings held with staff every three months. Inspectors reviewed a sample of probation and performance appraisals which included professional development and goal setting for staff. Staff were aware of the lines of accountability in the centre and knew who to report issues to. Staff who spoke with inspectors said they were supervised in their work and they were knowledgeable regarding the needs of residents, including the policy on safeguarding residents from abuse. They explained how they would protect residents and report any complaints or concerns of abuse.

The management team had some systems in place for the oversight of the quality and safety of care in the centre, and the provider was clearly involved within the running of the centre. The provider held regular management meetings where performance indicators for the centre were reviewed and discussed; for example on topics such as residents' welfare, staff, activities, complaints, and household issues. In addition, the centre completed monthly monitoring and data sheets of key resident data which included dependency levels, wound care, falls and restraints.

Inspectors reviewed a number of audits that the registered provider had conducted in 2021. However, inspectors were not assured that all audits were sufficiently comprehensive and resulted in quality improvements within the centre. For example, the care plan audit action plan which was discussed in the Clinical Governance Meeting in August 2021 did not include measures to ensure that care plans were formally reviewed as residents' care needs changed. In addition, the Infection Prevention and Control audit from June 2021 resulted in overall compliance of 90%. This audit tool did not highlight findings, seen by inspectors, relating to storage of items which could lead to cross contamination. In addition within this audit, it was noted that bathroom compliance was 75% due to storage of wheelchairs and armchairs in bathrooms. On the day of this inspection, this remained a finding with inappropriate storage of items such as wheelchairs, armchairs and other items such as hoists, chair scales and cleaning equipment seen in four shared bathrooms.

Inspectors spoke with staff who confirmed they were aware of the complaints procedure. Residents who spoke with inspectors said that if they have any concerns or complaints, they were dealt with quickly and they were comfortable highlighting issues to staff members. There was evidence within the complaints register that the provider worked hard to ensure that complaints or concerns received were resolved at an early stage. The provider also completed audits to ensure that complaints received were managed in line with their own policies and procedures.

Regulation 15: Staffing

On the day of inspection, inspectors found that the number and skill-mix of staff was appropriate with regard to the needs of the 83 residents, assessed in

accordance with Regulation 5, and the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to mandatory training. The person in charge informed inspectors that further dates for fire safety training had been scheduled.

Staff were appropriately supervised. A sample of records of probation and appraisal forms were seen which included action plans where improvements were required.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors found that a review of the management systems within the centre was required. For example:

- Inspectors did not see evidence that the analysis of some key information gathered by the provider from management meetings and audits was being used to inform service improvements. For example, a review of management meeting minutes in July 2021 discussed a practice within the centre regarding a monitoring device where the provider was seen to highlight resident privacy concerns, however no further action was seen. The provider had failed to identify this measure as restrictive or to act on the privacy concerns highlighted within this management meeting.
- Inspectors found that some quality improvement plans developed following audits were insufficient or the provider had failed to put these plans into action. For example, the Hygiene audit completed in June 2021 identified the storage of unnecessary equipment in domestic and housekeeping rooms. On the day of inspection, inspectors found examples within one cleaners store room where items were stored on the floor and two sluice rooms which had an arm chair, spare skirting boards, commodes and an anti-slip mat stored inappropriately. In addition, the Privacy and Dignity audit completed in July 2021, identified a finding of 93% compliance due to no private room being available for visiting. The action plan from this audit identified that this was to be made available as soon as possible. On the day of the inspection, this action plan had not been completed as inspectors were told there was no indoor visiting area.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was an accessible complaints procedure available in the centre which was prominently displayed for residents and visitors. The complaints policy dated January 2021 set out the steps to be taken to register a complaint, the complaints officer and indicated the appeals process to an independent officer.

Inspectors reviewed a sample of complaints from the centres complaints register. Records seen confirmed that closed complaints were well managed in the centre.

Judgment: Compliant

Quality and safety

While areas for improvement were identified in respect of the quality and safety of the service received by residents, overall, residents were supported by staff to have a good quality of life in a pleasant environment. Residents were able to choose how they spent their day and had access to good quality healthcare and to social activities throughout the week. This inspection found that improvements were required in relation to care planning, restrictive practices, visiting arrangements, inappropriate storage, infection control measures and fire precautions.

Inspectors reviewed a sample of resident records. A comprehensive pre-admission assessment was completed for the residents reviewed, which ensured that the centre could meet the personal, medical and social needs of each prior to them being admitted to live in the designated centre. A care plan on key assessed needs was developed within 24 hours of admission, followed by the completion of detailed assessments and need-specific care plans within two weeks of admission. A review of care plans assured inspectors that they were person-centred and demonstrated that evidence-based care was being provided to residents. However, the inspectors observed that a care plan did not contain sufficient and clear detail to guide staff to safely manage the resident's care.

Residents' health and well-being was promoted by regular reviews by general practitioners (GP) services, who visited the centre twice weekly or as required. Residents also had timely access to a physiotherapist who worked in the centre two days per week, and were referred to private and community health and social care professional services, such as occupational therapy, speech and language therapy, dietetics, dental, gerontology and tissue viability nursing, when requested by residents or as required.

Inspectors observed that for residents with a physical restraint, such as a bed rail, care plans were developed which evidenced and guided their use. However, the

provider did not recognise the use of some environmental restraints, such as sensor alarms, as restrictive practice. As a result, care plans had not been developed to guide staff on their use. These environmental restraints were also not included on the centres' restraint register, and therefore inspectors were not assured that the provider had sufficient oversight of their use within the centre. In addition, inspectors reviewed resident's records, and noted that consent forms on restraint had not been signed by residents, or where appropriate their families.

Residents enjoyed a daily programme of activities, which were led by a team of dedicated activity staff. Activities for the day were displayed on notice boards throughout the designated centre to identify to residents what was on offer each day from Monday to Sunday. Inspectors observed an exercise activity session attended by a number of residents and that residents were positively engaged in this activity.

Inspectors saw evidence of residents' rights being respected throughout the day of inspection. Staff were observed to engage with residents in a supportive manner and staff were observed to knock on residents' doors and announce their presence before entering resident's private space. Residents had access to telephones, newspapers and televisions. The provider facilitated regular resident meetings, and had taken action based on the information they received, such as bringing the centres' pet budgie to the vet for a health review.

The centres' visiting arrangements did not align with the most up-to-date Health Prevention Surveillance Centres' guidance, furthermore the risk assessment on visiting had not been updated to reflect the centres' visiting arrangements.

The centres' risk policy included the risks specified in the regulation, and referenced supplementary policies which provided guidance on the management of these risks. Some of the policies reviewed required updating to ensure that they were aligned with other policies and that they contained all necessary information. Inspectors reviewed the risk register, and noted that it was well maintained and regularly reviewed and updated as required. The centre had a comprehensive Safety Statement and an up-to-date plan to respond to major emergencies such as power outages and flooding.

Overall, inspectors observed there was evidence of good adherence to the appropriate wearing of PPE by staff and infection prevention and control practices in the centre. Residents and staff had accessed the COVID-19 vaccination programme with inspectors informed that there was 100% uptake within the centre. Inspections observed that staff tried to ensure that residents were able to keep themselves safe in the environment. For example, inspectors observed staff prompt a resident to carry out hand hygiene following sneezing.

Inspectors were concerned that the provider would not meet the requirements as per Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2016 Statutory Instrument (S.I.) 293 which was due to take effect on 1 January 2022 and brought this to the attention of the provider at the time of the inspection.

Inspectors observed that some areas of the building required repair such as a cupboard in a shared bathroom and flooring in areas of the centre. Inspectors also observed numerous items of inappropriate storage within a cleaning store room, sluice rooms, communal areas such as a day room and on corridors, and shared bathrooms. Inspectors found that due to this inappropriate storage, there was an impact on residents accessing some areas of the designated centre as well as infection control and fire risks.

Inspectors observed that within some of the multi-occupancy bedrooms, the layout and design of these bedrooms, did not afford all residents sufficient private space. Some privacy curtains on the day of the inspection were surrounding the residents bed only, and in some cases also included their bedside locker, but not their chair or wardrobe. Therefore if a resident wished to access their personal belongings in their wardrobe, they were required to exit their private space.

A review of the storage and segregation practices to minimise the risk of cross contamination was required. For example, some toiletries belonging to multiple people including bottles of shower gel, deodorant, a toothbrush, bar of soap and a labelled prescription ointment was seen in shared bathrooms. Inspectors were told that the centre was refilling soap dispensers which were single use only, which had the potential to cause contamination.

Staff who spoke with inspectors were knowledgeable regarding emergency evacuation procedures in the centre. Records provided to inspectors on the day of the inspection, showed that the provider was completing fire drills in single bedrooms. Inspectors requested evidence from the provider that fire drills for compartments had been completed. This evidence was requested on multiple occasions during the course of the inspection and feedback meeting, and during two subsequent telephone calls. This evidence was subsequently received and provided assurances that these fire drills had been adequately completed. Overall, inspectors were not assured that the provider had adequate oversight of fire precautions within the centre, as the provider had not completed a comprehensive fire safety risk assessment. Subsequent to the inspection, this risk assessment was requested to be submitted one month following the inspection and has not yet been received. In addition, inspectors noted inappropriate storage at fire stair wells and exit points. These findings will be further discussed within Regulation 28: Fire Precautions.

Regulation 11: Visits

Inspectors found that visiting arrangements within the centre were not in line with the Health Prevention Surveillance Centres' ''COVID-19 Normalising Visiting in Long Term Residential Care Facilities' guidance issued at the time of inspection. This guidance stated that designated centres should facilitate indoor visits for residents and that visits should be of unlimited duration.

However, the provider was not routinely facilitating indoor visits, other than on compassionate grounds. Inspectors found that the provider was facilitating visits,

between residents and their visitors, in two cabins located in the carpark of the centre and visit lengths were restricted to 30 minutes. Inspectors saw from resident meetings and within a record of feedback from families, that some residents and their families were dissatisfied with these arrangements.

Inspectors also noted that the centres' current risk assessment on visiting did not reflect the provider's current visiting arrangements.

Judgment: Substantially compliant

Regulation 17: Premises

Inspectors found that action was required to ensure the premises conformed with the matters set out in Schedule 6 as per Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. For example:

- There was wear and tear seen within the décor of the centre and some equipment required replacement. For example, flooring within one multi-occupancy bedroom was badly marked and the carpet within communal areas was worn. There was rust seen on a drying rack within a sluice room, a table in the smoking room was worn and damaged, and a lock was broken in a shared bathroom.
- The storage of furniture and residents equipment seen in one bathroom and one communal room in the Grange Wing prevented residents' from accessing these areas. Inspectors were told that the storage of items in the bathroom was due to insufficient storage of a residents' belongings in their bedroom. The storage of 15 wheelchairs and one hoist was seen in the communal area during the inspectors walk around the centre within the morning time. This floor space within this room was covered with the storage of these items. Inspectors were told this was to facilitate the cleaning and drying of these items the night before and the items would be expected to be removed from this area at 11:00am. Seven wheelchairs remained in this area at 1:22pm.
- Inspectors found that the private space for residents in some multi-occupancy bedrooms required review. For example, one private space seen for a resident within a four-bedded room had their bed within the privacy curtain. Their bedside locker, wardrobe and access to a chair was outside this area. Another three residents within three other multi-occupancy rooms did not have access to their wardrobe or a chair within their privacy curtain.

Judgment: Substantially compliant

Regulation 26: Risk management

The risk policy met the requirements of the regulations and addressed specific issues such as self-harm and the prevention of abuse. There was an up-to-date risk register in place, covering both clinical and health and safety risks, and each was controlled through the risk assessment process with an owner assigned to each and appropriate control measures put in place to reduce the risk.

The centre had a comprehensive Safety Statement in place and up-to-date plan to respond to major emergencies.

Judgment: Compliant

Regulation 27: Infection control

There were issues fundamental to good infection prevention and control practices which required improvement:

- Damaged tiles in bathrooms could not be effectively cleaned and decontaminated.
- Inappropriate storage presented a risk of cross contamination. For example:
    - clean incontinence wear stored out of packets
    - residents' personal hygiene products stored in shared bathrooms
    - cleaning sponges, scrubbing brushes and sweeping brushes stored in shared bathrooms. Inspectors were told that these sponges and brushes had been used by night staff to clean residents' equipment that had been soiled.
- Equipment such as soap dispensers designated as 'single use only' were reused and need to be disposed of appropriately.
- Residents' clothing and hip protectors were observed drying on radiators on corridors, which again could lead to cross contamination.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Action was required in how the provider was managing fire safety within the centre. For example:

- The provider had not ensured there was a current comprehensive fire safety risk assessment in place for the centre. When the risk assessment was requested by inspectors, documentation was provided by management relating to a list of works due to be completed in 2010 and subsequently a fire safety certificate from 2011.
- On the day of inspection, there was inappropriate storage such as boxes,

three laundry trolleys, a wheelchair and a fold-up bed seen at two fire stairwells and one exit point.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors observed that one wound care plan did not state how often dressings were to be changed. It also did not state the rationale for the dressing in use, which was not the dressing advised by the specialist Tissue Viability Nurse. As a result, this care plan did not contain appropriate guidance to support staff when caring for the resident.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had good access to general practitioner and physiotherapy services, and to other medical and health and social care professionals via a referral process. Inspectors also noted that eligible residents were facilitated to access the services of the national screening programme.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Inspectors observed that the provider did not acknowledge and assess some environmental restraints, such as sensor alarms, as a restrictive measure. Therefore, there was no oversight and review of this restrictive measure and no care plans developed to guide staff on their use. In the sample of residents' records reviewed, the use of sensor alarms was evident in two records but there was no assessment completed or care plan developed to guide their use. Sensor alarms were also not listed on either the 'Restraint' consent form or 'Safety intervention' consent form that the provider had developed for use with those in receipt of restrictive measures.

At the time of the inspection, inspectors were not provided with evidence that residents, or where appropriate their families, had provided signed consent on the use of restraint, as per the centres policy. Inspectors reviewed the restraint register for the Main House and saw that bedrails were in use for 21 residents. The register

also indicated that consent on the use of the bedrails had been obtained from only five of the 21 residents. This was not in line with the centre's own policy or national guidance on the use of restraint. Inspectors reviewed the records of eight residents listed on the restraint register and found evidence of consent in only two records.

Judgment: Not compliant

Regulation 9: Residents' rights

There were facilities for residents to engage in recreational and occupational opportunities, and to exercise their civil, political and religious rights. Residents had access to radio, television, newspapers and to the internet.

There was an independent advocacy service available in the centre and regular resident meetings were held.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ashbury Private Nursing Home OSV-0000007

Inspection ID: MON-0034389

Date of inspection: 04/10/2021

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider has undertaken and is well advanced in its annual review for care provided in the Centre in 2020. A quality improvement plan has been put in place in order to ensure compliance with audit results. The Provider has conducted a review of all matters identified by the Inspectors on the day of the Inspection and all outstanding quality improvement plans have been put into action. In relation to the practice highlighted by the Inspector by reference to the management meeting, this practice has now ceased.	
Regulation 11: Visits	Substantially Compliant
Outline how you are going to come into compliance with Regulation 11: Visits: The risk register of the Centre has been reviewed and updated by reference to our Centre's current visiting risk management practices. The Provider assures the Inspectors that the Provider will continue to risk manage our visiting practices in accordance with the level of risks we identify at the time, mindful of the HPSC developing public health guidance. Respectful of HSPC guidance our Centre will continue to receive compassionate visits indoors in line with our Centre's policies and procedures for visits.	
Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: The Provider has reviewed the statutory requirements of SI 293 including on advice from its solicitors. The Provider has taken all necessary steps to assure itself that it is in compliance with Paragraphs 1A to 1B of Schedule 6 of the Care & Welfare Regulations which do not enter into force of Irish law until 1 January 2022. The Provider has put plans in motion to address wear and tear and needs for upgrading works. These works envisaged by these plans will be completed within the next four-month period, respectful of public health restrictions and any restrictions on external service deliveries into our Centre. The storage issues identified by the Inspectors on the day of the Inspection have been addressed, including through Feedback on the regulatory report on the Inspection.	
Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: The Provider has put a plan of repair into action, any identified upgrading works will be addressed during this upgrade. In particular, the Provider confirms that any cracked tile noted within the Centre will be replaced in accordance with the Plan. Practices highlighted by the Inspectors, including personal items identified in bathrooms, have been addressed. The practice of single use items such as soap dispensers being refilled has been addressed. The Provider assures the Inspectors that all cleaning equipment is, and will continue to be, stored in the cleaners storage area. In order to address concerns of the inspectors on the day of the inspection, the Provider has conducted a review of staff hand hygiene practices throughout the Centre and the Provider has satisfied itself that no clinical staff engage in the practice of wearing stoned rings or nail varnish while discharging clinical duties within the Centre. Notwithstanding, hand hygiene practices have been re-enforced within the Centre.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The Provider is conducting a review of the adequacy of its current fire precautions. The Provider has engaged a fire safety consultant to undertake a risk assessment of the premises, including an electrical report. The fire safety consultant is working to a delivery	

date for the assessment report of 31 December 2021 respectful of the developing public health restrictions.
Temporary storage of items during on the day of the Inspection during a COVID-19 restriction event within the Centre affecting a secondary fire route was addressed on the day of the Inspection and items removed immediately.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
The Provider arranged for a review of approximately 1000 care plans following the Inspection, and acknowledges that a very small number of care plans had not been updated within the four-month time frame, due to the challenges of managing the COVID-19 pandemic.
The Provider has since completed a full audit of all care plans, and has now actioned all care plans by reference to the four month timeframe.
A full audit of care plans has been undertaken, and a system is in place to ensure that this is kept under review and actioned in a timely manner.
Furthermore, Inspector's advices regarding specifics required within each care plan have been taken on board and now addressed with the care plans.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
The Provider appreciates that the Inspectors on the day of the Inspection adjudged that the Provider was in full compliance with Regulation 9 of the Care & Welfare Regulations and our Residents' rights.

The Provider is grateful for the Inspectors' comments in the report on the Inspection by reference to the Provider's use of restraints or not in the context of managing challenging behaviour from residents within our Centre. With a focus on this aspect, the Provider conducted a review of its use of bedrails and floor sensors with a view to establishing their use in compliance with the Care & Welfare Regulations.

In our review, the Provider – on legal advice – has had regard to the ministerial definition of "restraint" which defines a restraint as any "intentional" restriction of a

person's "voluntary movement" or "voluntary behaviour".

The Provider assures the Inspectors that it follows a policy of obtaining signed consent forms for the use of bedrails regardless of whether or not the use of bed-rails actually falls within the legal definition or not of "restraint" under the Care & Welfare Regulations. When consent is sought, it is obtained from the resident where the resident is capable of providing consent and where the resident lacks capacity to give consent, it is obtained from his/her representatives. The Provider acknowledges that following its review a number of consent forms consenting to the use of bedrails require to be updated as part of our Centre's policy and we are currently engaged in that updating work.

The Provider also assures the Inspectors that it does not use floor sensors as a "restraint" within its Centre. The Provider assures the Inspectors that floor sensors are not used for the purpose of securing the intentional restriction of any of our residents' voluntary movement or voluntary behaviours.

The floor sensors are used solely for residents who are unable to use a call bell, including those residents who may be incapable of "voluntary movement" or "voluntary behaviours". The Provider is assured that involuntary movements including falling and residents who are unable to use their call bells, as a rule, require assistance to prevent injury from falling. The use of floor sensors in such scenarios by the Provider is an essential tool in its efforts to protect its residents from unnecessary or avoidable injury from falling and far from restraining movement by our residents actually safely operate to encourage movement in a safe and supported manner, where necessary and appropriate. The Provider, following its review of the use of floor sensors in its Centre, assures the Inspectors that sensors are not used for the intentional restriction of voluntary movement or voluntary behaviour in our Centre.

To assure the Inspectors in this regard, all care plans in respect of the use of floor sensors have been updated to guide staff in their use.

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 11(2)(a)(i)	The person in charge shall ensure that in so far as is reasonably practicable, visits to a resident are not restricted, unless such a visit would, in the opinion of the person in charge, pose a risk to the resident concerned or to another resident.	Substantially Compliant	Yellow	24/11/2021
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	25/02/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure	Substantially Compliant	Yellow	24/11/2021

	that the service provided is safe, appropriate, consistent and effectively monitored.			
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	25/02/2022
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	25/02/2022
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	12/11/2021
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident	Substantially Compliant	Yellow	24/11/2021

	concerned and where appropriate that resident's family.			
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Not Compliant	Orange	24/11/2021