| Centre name: | Ashbury Private Nursing Home |
| Centre ID: | OSV-0000007 |
| Centre address: | 1A Kill Lane, Kill O'The Grange, Blackrock, Co. Dublin. |
| Telephone number: | 01 284 1266 |
| Email address: | info@anh.ie |
| Type of centre: | A Nursing Home as per Health (Nursing Homes) Act 1990 |
| Registered provider: | A N H Healthcare Limited |
| Provider Nominee: | Robert Fagan |
| Lead inspector: | Sheila McKevitt |
| Support inspector(s): | None |
| Type of inspection | Announced |
| Number of residents on the date of inspection: | 86 |
| Number of vacancies on the date of inspection: | 12 |
About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- **Registration:** under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- **Monitoring of compliance:** the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
Compliance 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

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<tr>
<th>From</th>
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<tr>
<td>17 November 2016 09:30</td>
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<td>18 November 2016 09:30</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Compliant</td>
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<tr>
<td>Outcome 02: Governance and Management</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 03: Information for residents</td>
<td>Compliant</td>
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<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
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<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Compliant</td>
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<td>Outcome 06: Absence of the Person in charge</td>
<td>Compliant</td>
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<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Major</td>
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<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Compliant</td>
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<td>Outcome 09: Medication Management</td>
<td>Compliant</td>
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<td>Outcome 10: Notification of Incidents</td>
<td>Compliant</td>
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<td>Outcome 11: Health and Social Care Needs</td>
<td>Substantially Compliant</td>
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<td>Outcome 12: Safe and Suitable Premises</td>
<td>Substantially Compliant</td>
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<td>Outcome 13: Complaints procedures</td>
<td>Compliant</td>
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<td>Outcome 14: End of Life Care</td>
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<td>Outcome 15: Food and Nutrition</td>
<td>Compliant</td>
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<tr>
<td>Outcome 16: Residents’ Rights, Dignity and Consultation</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 17: Residents’ clothing and personal property and possessions</td>
<td>Compliant</td>
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<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Substantially Compliant</td>
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**Summary of findings from this inspection**

This inspection was announced following an application by the provider to renew the registration of the centre. As part of the inspection, inspectors met with residents, relatives and staff. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

Prior to the inspection, inspectors reviewed all documents submitted by the
nominated person on behalf of the provider, for the purposes of application to register and were found to be satisfactory.

The centre is registered to accommodate 99 residents and there were 86 residents on the day of inspection with one in hospital, leaving 12 vacant beds.

Inspectors found that the nominated person on behalf of the provider had addressed five of the six action plans from the last monitoring inspection which took place on 03 March 2016. The actions plans addressed included the completion of an annual review, the ceasing of use of non slip seat covers, the increase in consultation with residents' and the removal of personal information from communal notice boards.

The centre was found to be in compliance or substantial compliance with sixteen outcomes, in moderate non compliance with one outcome and in major non compliance with one outcome. The non compliances related to residents' rights, privacy and dignity and the safeguarding residents. Two staff working in the centre did not have a garda vetting disclosure in place and the use of bedrails as a form of restraint was not reflective of the national restraint policy. Screening in two twin rooms were not ensuring the privacy of residents'.

The action plans at the end of this report reflect these non-compliances.
Compliance with Section 41(1)(c) of the Health Act 2007 and 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.

Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
A statement of purpose was submitted as part of the application to renew registration application and a revised version was given to inspectors on this inspection. It had been reviewed in November 2016 and outlined the overall aim of the centre and other details as specified in Schedule 1 of the Regulations.

Staff were familiar with its content and a copy was on display in the centre.

Judgment:
Compliant

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
There was a clearly defined management structure which was reflected in the statement of purpose.
The family run centre was managed by members of the Fagan family. The provider, person in charge (PIC) and general manager worked fulltime across the two centres owned by the family, this centre and another situated approximately 6kms away. They had offices in both nursing homes and met daily. Inspectors were informed that all three met on a monthly basis to discuss management issues.

The person in charge was supported in her clinical role by an Assistant Director of nursing (ADON) and five clinical nurse managers (CNMs). The nurse in charge on both units of the nursing home (the main house and grange wing) reported to the person in charge verbally and via email at the end of each shift, examples of this communication were available for review. She met with members of the nursing management team on a regular basis, minutes of these meetings reflected clinical issues they discussed such as, medication management, auditing practices and action plans to be addressed following audits being conducted.

The ADON was the named person to take over in the absence of the person in charge. She held this post at the time of the last registration inspection also. She is a registered general nurse and completed a Masters in Mental Health nursing in 2013.

The person in charge was auditing areas of practice such as medication errors, care plans, nursing documentation, use of bedrails accident and incident and falls. The results of most of these audits were clearly analysed, and communicated to staff. Where action plans were included there was evidence that these actions had been addressed by the person in charge. For example, the findings of two recent audits did not include an action plan, it was not clear what improvements had occurred as a result of these two audits.

An annual review of the quality and safety of care delivered to residents had taken place since the last inspection. A copy had been submitted to the Authority. Inspectors were informed that satisfaction surveys' were being prepared for issuing to residents' in preparation for the 2016 annual review.

**Judgment:**
Substantially Compliant

**Outcome 03: Information for residents**
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Inspectors found that there was a guide available in respect of the centre and a written
contract of care in place for each resident.

There was a guide available in the centre. Inspectors were informed that a copy was provided to each resident on admission. The guide contained all the required information as per regulation 20.

Inspectors reviewed a sample of residents' contracts of care. All those reviewed contained information in relation to the care and welfare of the resident and the services that would be provided to the residents. They set out the weekly fees that were to be charged. The sum paid by fair deal and additional fees which was paid by the resident or their next of kin was clearly outlined. The contracts also detailed an additional monthly charge for provision of 'additional services'. The additional monthly charge was detailed in the contract of care some were fixed such as that implemented for the social programme others were charges applied only when the service was availed of by the resident.

Each contract of care had been signed by the provider, a witness and the resident or their next of kin.

**Judgment:**
Compliant

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### Outcome 04: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The centre was managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service. She demonstrated a good level of clinical knowledge and knowledge of the regulations and her legislative responsibilities.

She has been joint person in charge of the centre and another designated centre (situated approximately six kms away) since 2006. She therefore has 3 out of 6 years experience of working with older people. She works fulltime, is a registered nurse and has completed a post Graduate Diploma in Leadership. Residents’ spoken with were aware of her name and role.

**Judgment:**
Compliant
**Outcome 05: Documentation to be kept at a designated centre**

The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Inspectors found the records listed in schedules 2, 3 and 4 of the regulations were maintained in a manner to ensure completeness, accuracy and ease of retrieval. The centre had all operational polices as per schedule 5 of the regulations.

Inspectors reviewed residents' records. The directory of residents contained all of the information required in schedule 3. A sample of resident's files reviewed contained all of the health and medical information as listed in schedule 3. Inspectors saw that centre was adequately insured.

Inspectors reviewed the operational policies and found that most reflected the practice. However, some such as the use of restraint were not reflecting best practice guidelines outlined in the National policy. The recruitment policy was reflective of legislative requirements, however, there was evidence that it was not reflected in practice. All policies reviewed had been updated at least once in the past three years.

A sample of five staff files were reviewed and three of the five were found to contain all the requirements as per schedule 2 of the regulations. This is discussed further under outcome 7.

All other records as per schedule 4 were maintained and readily available.

**Judgment:**
Compliant

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**Outcome 06: Absence of the Person in charge**

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The person in charge was aware of the requirement to notify the Chief Inspector of any proposed absence for a period of more than 28 days. There were appropriate arrangements in place for the management of the centre during any such absence.

**Judgment:**
Compliant

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**Outcome 07: Safeguarding and Safety**
*Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.*

**Theme:**
Safe care and support

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**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
The centre had a policy on the prevention, detection and response to abuse.

Inspectors spoke to a number of staff and all staff spoken to were knowledgeable around the signs of abuse and what to do in the event of an allegation or suspicion of abuse. Staff also relayed that they would have no issue in reporting any alleged incident of abuse to management the centre. Inspectors reviewed the staff training records and found that all staff had received up to date training around safeguarding residents.

Two health care assistants rostered to work in the centre were found not to have a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. There was evidence in the two staff files that garda vetting had been applied for, up to three times, however a vetting disclosure in accordance with the National Vetting Bureau had not been received. The provider was requested to inform the Authority within one working day of the action/s they would take to address this. The provider submitted a response as requested, however the Authority found this response did not provide assurances that vulnerable residents’ were protected at all times.
The centre had a policy in place on responding to residents who may display responsive behaviours. Inspectors reviewed residents’ care plans and found that they detailed residents’ triggers and the various steps to be taken in order to distract or de-escalate in the event of a resident displaying responsive behaviour. On a number of occasions inspectors observed staff recognising triggers and immediately responding, calming the residents using the same steps as detailed in the residents’ care plans. Records reviewed showed that staff had received training in this area.

Inspectors saw there were several different types of alternative equipment available such as low low beds, alarm mats and crash mattresses. The sample of restraint assessments showed that assessments did not consistently outline what if any of these had been trialled, tested and failed prior to bed rails being used as a form of restraint. Also, the terminology used in one document required review. Practices observed did not always reflect best practice, for example, one resident was observed in bed with both bed rails up, a low low bed was in use and there were crash mats on the floor, on both sides of the resident's bed. The centres policy on use of restraint did not reflect the National policy and therefore required review. For example, it did not state all the alternatives available in centre which could be trialled and tested prior to a restraint been used. Also, it did not reflect the recommended assessment forms to be used. This issue was identified on the last inspection and had not been addressed to date.

The management of residents' finances was reviewed and found to be safe. However, they were not in line with the centres policy point 7.5.1; which states that the provider will set up a separate account for the resident so that arrangements can be made for the resident's pensions to be sent to this account.

Judgment:
Non Compliant - Major

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The health and safety of residents, visitors and staff was promoted and protected.

The centre had a risk management policy, an emergency plan and an updated health and safety statement in place. The risk register was comprehensive and kept updated. It identified risks and specific measures put in place to reduce the level of risk.

Records reviewed on inspection showed that the fire alarm and the emergency lighting was serviced on a quarterly basis and fire safety equipment was serviced on an annual
basis. Staff spoken with were clear on what to do in the event of the fire alarm sounding. Most staff had completed fire safety training within the past year and those who had not were scheduled to attend. Records reviewed showed that fire drills were practiced on a weekly basis. Residents' were involved in some depending where the fire was located. Records of these fire drills were comprehensive reflecting those in attendance, times and any issues identified which required improvement. Inspectors saw that there was adequate means of escape and fire exits were unobstructed.

Manual handling practices observed were in line with best practice and records reviewed showed all staff had up-to-date training in place.

Infection control practices were good overall with hand washing and drying facilities and hand sanitizers were available throughout the centre. However, a few small issues required review; the ventilation in the dirty utility upstairs in the Grange wing and in the smoking room did not appear to be working effectively and the practice of storing dirty linen in the ensuite of one upstairs bedroom when morning care was being provided required review. The automatic door release on bedroom door of room 601 was not working. The provider informed inspectors that these issues were being addressed prior to the end of the inspection. These issues are included in action plans under outcome 12.

Judgment:
Compliant

Outcome 09: Medication Management
Each resident is protected by the designated centre’s policies and procedures for medication management.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors reviewed the practices and documentation in place relating to medication management in the centre. There were written policies in place relating to the ordering, prescribing, storing and administration of medicines to residents.

All medicines were stored securely in the centre. medicines dispensed in a monitored dosage system that consisted of individual pouches. Medicines were stored securely within the centre, and fridges were available for all medicines and the temperature of these fridges was monitored. All controlled (MDA) medicines were stored in secure cabinets, and registers of these medicines were maintained with the stock balances checked and signed by two nurses at the end of each working shift. There were procedures in place for the handling and disposal of unused and out of date medicines.

Inspectors reviewed the processes in place for administration of medicines, and were
satisfied that nurses were knowledgeable regarding residents’ individual medication requirements. Nursing staff were observed to safely administer medicines. Practice observed reflected the policies.

The pharmacist was facilitated to meet all necessary obligations to residents in accordance with guidance issued by the Pharmaceutical Society of Ireland, and visited the centre on a regular basis, conducting reviews of residents’ medications and medication audits.

Medication incidents including medication errors were recorded and nursing staff spoken with were knowledgeable of the procedure to be followed. The person in charge was monitoring medication errors.

**Judgment:**
Compliant

**Outcome 10: Notification of Incidents**
*An record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
A record of all incidents occurring in the designated centre was maintained. A notification was provided to the Authority within 3 days of the occurrence of any incident set out in paragraphs 7(1) (a) to (j) of Schedule 4 since the last inspection.

A quarterly report was provided to the authority to notify of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4. A report had been provided to the Authority at the end of each quarter.

When the cause of an unexpected death was established, the Authority was informed of that cause.

**Judgment:**
Compliant

**Outcome 11: Health and Social Care Needs**
*Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/ her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/ her changing*
needs and circumstances.

Theme:
Effective care and support

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Inspectors were satisfied residents’ health care needs were met being met and residents had opportunities to participate in meaningful activities, appropriate to their interests. An issue identified on the last inspection report had been addressed.

Residents had access to general practitioner (GP) services and a full range of other services was available on referral including speech and language therapy (SALT), dietetic services, physiotherapy and occupational therapy. Chiropody, dental and optical services were also provided. Psychiatry for older persons community services were also been consulted.

Nursing assessments, care planning and additional clinical risk assessments were carried out for residents. Residents' with identified needs had care plans in place to reflect these needs. There was evidence that residents and/or relatives were involved in the development of their care plans. Inspectors found that most care plans including end of life and activity care plans were detailed and resident specific. Some residents’ care plans did not consistently reflect resident specific information to guide care. For example, the nutritional care plan of a resident identified as having weight loss did not reflect all the recommendations made by the dietitian during a recent visit.

While the evidence was that care delivery was largely in line with evidence based practice for most residents, some care plans did not reflect the rationale for some care practices. For example, inspectors observed (in the main house) a number of residents' were returned to bed fully clothed post having been provided with morning care. Two different rationales were given for this practice neither of which were reflected in the residents’ care plans. Residents' observed in bed with no access to their call bell did not have a risk assessment in place to reflect the risk associated with them having a call bell, as described to inspectors. The rationale for this practice was not reflected in the residents' safety care plan. Post this inspection updated care plans containing the rationale for this practice were forwarded to the lead inspector.

Daily notes were being recorded in line with professional guidelines. The person in charge had identified gaps in nursing documentation through consistent auditing of nursing documentation. Additional training had been provided to staff and there was a plan in place to re-audit to determine if practice had improved.

There was an adequate policy in place on falls prevention to guide staff. Inspectors read records of residents who had fallen and saw that risk assessments and care plans were updated post their fall. Preventative measures undertaken included the use of bed, chair alarms and hip protectors. The person in charge was auditing falls and conducting a
critical analysis on all those which resulted in serious injuries. Residents’ who sustained a fall were reviewed by the in house physiotherapist.

**Judgment:**
Substantially Compliant

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**Outcome 12: Safe and Suitable Premises**

The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Theme:**
Effective care and support

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**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Ashbury Nursing Home is divided into two separate units connected by a link corridor. The main house is a three-storey renovated old building and the Grange unit is a purpose-built recently extended two storey unit. Each floor was accessible by a lift. The centre was clean, comfortable, welcoming and well maintained both internally and externally. There were additional assisted bathrooms, toilets, sitting rooms, kitchen, dining rooms, dirty utility rooms, staff facilities and treatment rooms. There was three large communal areas in the grange wing which a number of residents’ living on ground floor of the main house used. Residents had access to two safe secure garden areas. Inspectors were informed that three assisted baths had been removed from bathrooms as they were not being used, two were in storage and available for use if required.

The centres multi-occupancy bedrooms, 3 (4) bedded and 3 (3) bedded met the needs of the residents' residing in them. They were large, bright, and contained an adequate amount of personal space around each bed. Each bed space had an adequate amount of storage space and screening provided. Where residents of maximum dependency required additional space the management team reviewed the number of residents’ occupying these rooms. For example, inspectors saw two residents’ occupied a three bedded room due to their assessed need for additional space.

Appropriate assistive equipment was provided to meet residents’ needs such as hoists, seating, specialised beds and mattresses. Inspectors viewed the servicing and maintenance records for equipment such as hoists and lifts and found they were up to date. Inspectors observed equipment being stored in the circulation area upstairs in the main house, beneath stairs and on stair landings.

There were handrails and safe floor covering throughout most of the centre. However, inspectors observed that there was no hand rails on the link corridor joining the main
The house and grange wing. The provider informed inspectors that this issue was being addressed prior to the end of the inspection.

Judgment:
Substantially Compliant

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Complaints made were managed in line with the centre's complaints policy. The complaints policy met the legislative requirements and was clearly outlined in the statement of purpose and the residents guide. The process was clear, accessible to all residents and displayed in prominent places throughout the centre.

The person in charge was the nominated person to deal with all complaints. The inspector reviewed records of complaints received since the last inspection, all had been fully investigated with clear concise records kept including the residents' level of satisfaction with the outcome of the complaint. The named appeals person was the provider and the general manager oversaw the complaints process. There was evidence that this was done on a three-monthly basis.

Residents' had access to an independent advocate and a second advocate acting specifically on behalf of residents' with dementia.

Judgment:
Compliant

Outcome 14: End of Life Care
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.
Findings:
The policies and practice in place ensured that each resident received care at the end of their life which met their physical, emotional, social, psychological and spiritual needs and respected their privacy, dignity and autonomy.

A group of twelve staff (which included at least one representative from each department within the centre) were working with the Irish Hospice foundation to promote best practice in end-of-life care delivered to residents.

Inspectors reviewed the files of a number of residents' one of whom was receiving end of life care. All residents' had a detailed person centred end-of-life care plan in place. They included the residents' religious, cultural and personal preferences such as details of their preferred resting place. It was evident that this plan of care had been discussed with the resident prior to their condition deteriorating. Inspectors were informed that residents occupying multiple occupancy rooms were facilitated to move into a single room if available and if they so wished.

The centre had access to a palliative care team and there was no delay in seeking their expert advice.

There was a private visitors room available to residents' which contained furniture facilitating the dying residents family to stay overnight. Residents' were facilitated to attend funerals. On the day of this inspection a number of residents' together with a member of staff attended a funeral on the centres own bus. One resident spoken with on their return told inspectors it was important to say farewell to those they had lived with.

Judgment:
Compliant

Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There was a policy in place for the monitoring and documentation of nutritional intake.

Residents had access to fresh drinking water at all times. Residents stated that the food
provided met their needs and overall they received a good variety and choice in sufficient quantities at each meal time. Meals and snacks were available at times suitable to residents. The inspector saw that the special dietary requirements of each resident were provided for. There was an updated reference list containing information regarding the residents preferred diet and the consistency each residents food and drink needed to be served at.

Food appeared to be properly prepared, cooked and served, and appeared wholesome and nutritious.

Inspectors saw evidence that residents' with a weight loss which was of concern to staff had been reviewed or had been referred and were awaiting review by a dietitian. Nutritional supplements recommended by the dietitian were being administered to the resident as prescribed by the resident's GP.

**Judgment:**
Compliant

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**Outcome 16: Residents' Rights, Dignity and Consultation**
Residents are consulted with and participate in the organisation of the centre. Each resident’s privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Inspectors were satisfied that staff treated residents with privacy and dignity. Issues identified on the last inspection had been addressed in full. Inspectors observed that the screening in two twin rooms did not facilitate residents' to undertake personal activities in private. Also, the routine use of protective clothing for residents' who required assistance at meal time required review to ensure residents' dignity was maintained.

Staff were observed knocking on bedroom, toilet and bathroom doors and waiting for a response to enter and this was confirmed by residents. The inspector observed staff interacting with residents in a friendly and courteous manner.

Residents’ civil and religious rights were respected. Residents' were registered to vote and they were facilitated to do so in the centre or at the local polling station. Mass took place twice to three times per week in the large sitting room. Residents' also had access to a Church of Ireland service as required.
A residents advocacy committee established and met every two months and the person in charge explained that she reviewed the minutes of these meetings and acted upon any requests. Residents’ had access to an independent advocate and a second advocate had just come on board acting specifically on behalf of residents' with dementia. The management also undertook a satisfaction survey annually to obtain feedback from residents' and their families. The findings were included in the centre's annual review.

Residents were seen partaking in some activities during the inspection. Five activity coordinators were employed to provide opportunities for meaningful engagement to all residents. Records were maintained on residents' interests and participation in activities each day. A programme of events was displayed and included religious ceremonies, Sonas (a therapeutic programme specifically for residents with dementia), music, movies, quizzes, flower arranging and many more. Residents’ told inspectors that they went out to different events in the local community which were organised by the activity coordinators. They had regular outings for coffee, lunch and shopping. Access to the centres own private bus meant these trips occurred on almost a daily basis. The feedback on residents’ questionnaires about the availability of activities inside and outside the centre was extremely positive.

Inspectors observed that the screening in two twin rooms 108/109, and 110/111 did not facilitate residents' to undertake personal activities in private. The screening in the both rooms did not extend completely around the residents' beds.

The use of protective clothing for those who required assistance at meal time required review to ensure residents’ dignity was maintained. Inspectors observed that in the main house (where a high number of maximum dependent residents' with dementia lived) staff were observed assisting residents' at morning tea and at lunch time were not consistently asking them if they wished to use protective clothing prior to having it placed on them. A sample of residents' nutritional care plans were cross referenced and they did not reflect this as a preference.

**Judgment:**
Non Compliant - Moderate

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**Outcome 17: Residents' clothing and personal property and possessions**

**Adequate space is provided for residents’ personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.**

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.
Findings:
Residents were able to maintain control over their personal property and appropriate storage facilities for their belongings were in place.

All laundry was outsourced. Laundry was collected and returned daily. All clothing was seen to be labelled for each resident. An inventory was also kept of each individual resident’s personal belongings.

Residents confirmed that they had adequate storage facilities in their bedroom which included their a personal wardrobe and a bedside locker/storage space.

Judgment:
Compliant

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There were sufficient numbers of staff with the right skills, qualifications and experience to meet the assessed needs of the 87 residents in the centre at the time of this inspection.

There was an actual and planned staff rota. Inspectors saw that there was a minimum of one staff nurse on duty at all times and the numbers of staff rostered during the day and night took into account the statement of purpose and size and layout of the building. Residents spoken with confirmed that staffing levels were good, stating they never had to wait long for their call bell to be answered or their requested needs to be met.

Residents spoken with told inspectors that staff were kind, patient and they felt well looked after. The feedback received on questionnaires was also extremely positive.

Records reviewed confirmed that all staff had mandatory manual handling and protection of vulnerable residents' training in place. There were a number of staff who
had not attended refresher fire training within the past year. However, inspectors were informed that all were scheduled to attend training on two dates, 22 November and 02 December 2016. Post the inspection the Authority received confirmation of those who attended this training on 22 November 2016 and that the remaining twenty staff would be completing this training on 02 December 2016. Staff had also been provided with in-house education on a variety of topics, such as, dementia care, end-of-life care, infection control and care planning. This enabled staff to provide care that reflects current best practice.

Staff spoken with told inspectors their learning and development needs were being met and they demonstrated a good knowledge of most policies and procedures. However, inspectors found and evidence reflected in outcome 7 indicated that qualified staff needed to familiarise themselves further with the National policy towards a restraint free environment. Inspectors received evidence post this inspection that 22 of the 23 qualified staff currently scheduled to work had completed refresher medication management training in 2016. Inspectors were told that there was an appraisal system in place for all staff, however these had not been completed with staff since 2014. The person in charge said she planned to commence these appraisals once again with staff. The re-introduction of such a process would enable senior management and clinical nurse managers ensure staff had their training needs met.

Inspectors saw that all qualified staff were registered to practice in 2016 with Bord Altranais agus Cnáimhseachais na hÉireann.

**Judgment:**  
Substantially Compliant

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**Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings.

**Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

**Report Compiled by:**

Sheila McKeivitt  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider’s response to inspection report¹

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Ashbury Private Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000007</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>17/11/2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>23/12/2016</td>
</tr>
</tbody>
</table>

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Where audit results identify areas for improvement, ensure action plans are developed, actioned without delay and the area of practice re-audited to determine if practice has improved or not.

1. Action Required:
Under Regulation 23(d) you are required to: Ensure there is an annual review of the

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take: We currently operate an auditing system for staff files however an oversight had been made in the collection of documents thus two files were missing one document each as per Schedule 2. These documents have now been obtained, and thus these staff files are deemed complete. However a file search will be undertaken as part of a routine audit system so as to ensure further oversights do not occur.

The results of clinical audits will be cohesively monitored and trended with any / all outcomes identified and actioned within specific timeframes. There will be a further follow-up to ensure the actions have been completed. The practice of re-auditing where a gap has been identified will be implemented and will be ongoing. The results of the audits undertaken throughout 2016 will be compared to the results from 2015 and will be published in our Annual review 2016.

Proposed Timescale: 31/03/2017

Outcome 07: Safeguarding and Safety
Theme: Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect: It was not always evident that restraint in use for each resident was used in accordance with national policy.

The use of restraint policy did not reflect the content of the National policy.

2. Action Required: Under Regulation 07(3) you are required to: 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.

Please state the actions you have taken or are planning to take: All staff are currently undergoing retraining on the National Policy which will be complete by end of January 2017, furthermore our Restraint Policy is under review, with a specific focus on highlighting the interventions taken prior to initiating any type of restraint, specifically bedrails. This will be complete by end of January 2017. In conjunction with our current equipment (low low beds, crash matts, sensor alarms) we are currently investigating the purchase of new equipment on the market to reduce the incidence of bedrails where appropriate, specifically inflatable triangle bumpers. This will be rolled out in early 2017, up to and including end of March 2017, however implementation of the national policy is underway already.
**Proposed Timescale:** 31/03/2017

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The management of residents' monies although clear did not reflect the centre's policy.

**3. Action Required:**
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

**Please state the actions you have taken or are planning to take:**
Policy has since been updated in order to provide clarity on our practice.

**Proposed Timescale:** 18/11/2016

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
All staff working in the designated centre did not have a garda vetting disclosure in place.

**4. Action Required:**
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

**Please state the actions you have taken or are planning to take:**
Following the instruction from the Inspectorate to ensure the safety of all residents, due to the fact that two staff Garda Vetting documents had not been obtained, despite an application having been made on three occasions for each, a submission was made to the chief inspector, laying down the interventions we had in place to ensure the welfare and safety of all residents. Those measures were to reduce one HCA to laundry duties, for one week and then to allow her to take a further week annual leave. The second staff member was allocated day duty, under supervision and to work Monday to Friday, so as to ensure maximum management would be in place to supervise. However this was not deemed to be satisfactory.

None the less, we have since obtained the documentation, both were clear of any convictions, an oversight had occurred in The National Vetting Bureau. As per the previous actions, we will audit all files to ensure that they contain all of the required documentation in Schedule 2.

We will submit a separate submission to the Chief Inspector with regard to this specific outcome.
Proposed Timescale: 01/12/2016

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plans did not consistently reflect the care being provided to residents’, for example the risk associated with using call bells.

Care plans were not consistently updated with recommendations made by members of the allied health care team.

5. Action Required:
Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

Please state the actions you have taken or are planning to take:
Care plans have since been updated, this was completed during the inspections and were forwarded to the inspector on the 21st November, a further system of robust auditing has since been implemented to prevent any omissions going forward. For example on a monthly basis random care plans will be pulled by the PIC to ensure they reflect the care being suggested by MDT as well as best evidence. Furthermore, care planning training efficacy will be assessed and will be checked in audit in January 2017 post care planning training having been completed in November 2016.
All risk assessments, are now kept along with the care plans and are reflected in the care plans, and not maintained as separate documents as was previously being done.

Proposed Timescale: 19/11/2016

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Equipment was stored in circulation area upstairs in the main house, beneath stairs and on stair landings.
Ventilation in dirty utility upstairs in the Grange wing and the smoking room did not appear to be working effectively.
The storage of dirty linen in the ensuite of one upstairs bedroom when morning care was being provided required review.
The automatic door release on bedroom door of room 601 was not working.
A handrail was not available on the link corridor which had a incline.
6. Action Required:
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:
The equipment has since been removed and relocated and so no longer causes any risk to safety or health.
Ventilation was actioned on the day of inspection, completed 17th November 2016.
The practice of storage of dirty linen in an en-suite has ceased, we have revised this practice and have relocated the linen, complete since 21st of November.
The automatic door in 601 was repaired on the day of inspection, complete since 17th November.
Hand rails are not required on both sides of every corridor, as per the regulations and the judgement framework, however a handrail has since been implemented along one side of the link corridor

Proposed Timescale: 23/11/2016

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Ensure that residents' are given the choice to use protective clothing, and is reflected in their care plan.

7. Action Required:
Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

Please state the actions you have taken or are planning to take:
All residents are given the choice where they are able to voice their preferred option in relation to the use of protective clothing, however this has now been introduced into their care plans ensuring that the care plans is specific about offering choice and style of protective apron. These care plans will be audited three monthly to ensure they reflect the care being delivered.

Proposed Timescale: 30/11/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The screening in twin rooms 108/109, and 110/111 did not ensure the privacy of residents' living in these rooms.
<table>
<thead>
<tr>
<th><strong>8. Action Required:</strong></th>
<th>Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
<td>This was rectified immediately on the days post inspection. As per the explanation on the day of inspection 108 / 109 was an oversight due to a previous preference expressed by a resident in the way their bed was facing. 110 / 111 was amended in the week post inspection.</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong></td>
<td>23/11/2016</td>
</tr>
</tbody>
</table>

| **Outcome 18: Suitable Staffing** |  |
| **Theme:** | Workforce |
| **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** | There was evidence that further training to all qualified staff on the National policy towards a restraint free environment. |
| **9. Action Required:** | Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training. |
| **Please state the actions you have taken or are planning to take:** | All clinical staff (HCAs, activity and nursing) are currently undergoing a program of retraining in relation to The national policy, this training involves testing knowledge as well as attendance at a training workshop. Specific reference to trying to reduce bedrails where assessment indicates it may be safe to do so, specifically carrying out thorough assessments and documenting all alternatives prior to implementing bedrails is being focused on in the training. Educating staff on the available alternatives to bedrails is also highlighted in the education sessions. In conjunction with our current monthly audit and trending programme, further analysis of alternatives trialled will be required outcomes of this practice. |
| **Proposed Timescale:** | 31/01/2017 |