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:	Aclare House Nursing Home
Name of provider:	Aclare Nursing Home Limited
Address of centre:	4/5 Tivoli Terrace South, Dun Laoghaire, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	01 October 2024
Centre ID:	OSV-0000001
Fieldwork ID:	MON-0041154

About the designated centre

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

Aclare House occupies a prime location, a short distance from the centre of Dun Laoghaire. It has views overlooking Dun Laoghaire Harbour and has a large landscaped enclosed garden. It can accommodate 27 residents, both male and female above the age of 18. The centre caters for a range of needs, from low to maximum dependency and provides short term care, long term care, convalescence care and respite care.

The centre comprises of nine single rooms some of which are en-suite and nine twin rooms, some of which are en-suite. Other accommodation includes a computer area, assisted bathrooms, showers rooms, designated smoking area, staff facilities, kitchen, laundry, sluice room. There are communal areas for use by residents such as the lounge, dining room, conservatory and visitor's room.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	26

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 1 October 2024	08:55hrs to 17:35hrs	Karen McMahon	Lead
Tuesday 1 October 2024	08:55hrs to 17:35hrs	Frank Barrett	Support

What residents told us and what inspectors observed

Aclare House Nursing Home, is located in Dun Laoghaire, Co. Dublin. During this inspection, inspectors spent time observing and speaking to residents, visitors and staff. The overall feedback from residents' was that they liked living in Aclare House. Residents' spoken with were complimentary of the staff and said they were good to them. Inspectors observed that the staff showed a kind and caring attitude towards the residents' they cared for. However, inspectors found that significant fire risks, identified on the day of inspection, were impacting the safety of residents, staff and visitors in the centre. This will be further discussed within this report.

On arrival to the centre the inspectors were met by the person in charge. After a brief introductory meeting the person in charge accompanied the inspectors on a tour of the premises. A named representative from the registered provider accompanied inspectors at a later stage in the tour.

The premises was two old Victorian style buildings that had been reconfigured into one building. It was laid out over three main floors, including a basement level. There were also a number of smaller areas located between the main floors that had various rooms located there including bedrooms, office space and a dual purpose bathroom and hairdressing space. Residents bedrooms were located in all areas of the premises. There were two communal spaces available to residents made up of a large sitting and dinning room and a conservatory. There was plenty of sunlight in the conservatory with a nice view of the garden space outside. The garden was to the rear of the centre, and had within it, numerous seating benches placed at intervals around the perimeter. There was a planting space, and some old features within the garden. All floors were accessed using two separate stairways. One of the stairways had a chair lift installed. There was no passenger lift available at the centre.

Residents' bedrooms were made up of a mix of nine single rooms and nine twin rooms. Residents' had access to either an ensuite or to a shared bathroom. Many residents had personalised their rooms with photographs and personalised possessions. In general twin rooms were laid out to ensure the residents living in these rooms had their privacy and dignity maintained at all times. However in one bedroom one resident had no access to the sink, should the other resident have the privacy screen pulled over, as it was located in that resident's personal space.

The inspectors observed that many residents were up and dressed and participating in activities, during their walk around the centre. A number of residents were seen to have the national newspapers. Activities were seen to take place in the sitting room during the day, while this room held a large number of residents the circulation space was limited and residents had to sit with their chairs lined up against the walls, in order to allow a clear evacuation route from the room.

The inspectors observed that dinnertime in the centre's dining room was a social and unhurried occasion for residents, who sat together in small groups at the dining tables. Residents were observed to chat with other residents and staff. The dining room had four tables located in it with four residents around most tables. Inspectors observed that the space between tables was limited and didn't facilitate a clear pathway for anyone that used a mobility aid to mobilise.

Residents who required assistance at mealtimes were observed been assisted in the sitting room area of the room. Inspectors observed that staff who provided support to these residents did so in a patient and kind manner. There were two choices available for dinner and hot and cold options available at tea time.The lunch was observed to be well presented, warm and with ample amounts on the plate. The meals were home cooked on site.

The inspectors spoke with many residents and some visitors on the day of inspection. All were positive and complimentary about the staff and had positive feedback about their experiences residing in the centre. One resident said that it was great living here and there was always someone to talk too and the location allowed for their family members to visit on a regular basis.

Visitors also echoed the feelings of residents and said they were always made feel welcome when visiting and were assured that their loved ones were well looked after.

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

Capacity and capability

Overall the inspectors found that there was a good level of compliance with the management systems in place that over see the quality of clinical care provided to residents. However, there were significant concerns around the oversight of safety in the premises with particular regards to the risk of fire and the impact this had on the safety of residents living in the centre. Significant actions would now be required to be taken by the registered provider to address the oversight of safety in the centre and ensure the lives of residents were protected from the risk of fire.

This was an unannounced inspection conducted over one day to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. This inspection also followed up on the compliance plan from the last inspection in November 2023 and

reviewed solicited information received. No unsolicited information had been received since the previous inspection.

The centre is owned and operated by Aclare Nursing Home Limited, who is the registered provider. There were clear lines of accountability and responsibility in relation to governance and management arrangements for the centre, however, this structure was not effective to ensure appropriate oversight of fire safety arrangements as discussed later. The person in charge was supported by two company directors, who were present in the centre daily on Mondays to Fridays and outside of these times if required. Other staff members include, nurses, health care assistants, activity coordinators, domestic, laundry, catering and maintenance staff.

There was a directory of residents made available to the inspectors. Overall, this had all the required information in relation to residents' admissions and next of kin details. However, not all entries were completed and a number of entries were noted ot be missing addresses for next of kins and GPs and in one entry there was no contact number for the GP.

A selection of staff files were reviewed on the days of inspection. All files inspected were observed to contain all relevant documents, as set out in the regulations. There was evidence of Garda vetting and relevant training in all files, as well as relevant proof of identification and references.

On review of the incident log the inspectors found that one death which required emergency treatment had not been reported as an unexpected death, as set out under schedule 4 paragraph 7(1) of the regulations. The death had been reported under the quarterly notifications, for expected deaths, as set out in the regulations. However the inspectors found that the events around the death indicated that the death had not been expected.

The premises was arranged over three floor with residents bedrooms on each floor. The communal spaces were all on the upper ground floor. The centre was not equipped with a passenger lift. This meant that residents who were not mobile, had access to a chair lift. While this was usable by some residents, it did not facilitate easy movement through the floors for residents with high levels of dependency, or who mobilised through the use of a wheelchair, as there was no facility to move the wheelchairs up or down the stairs. These issues are discussed under regulation 23; Governance and Management and Regulation 17: Premises.

Inspectors reviewed the management of fire safety risk within the centre. A Fire Safety Risk assessment (FSRA) viewed by inspectors which had been completed by a consultant in 2022, identified significant fire safety risk within the centre. The subsequent FSRA report categorised the risk to life in the event of a fire as substantial. Inspectors reviewed the actions taken by the provider to reduce the risk since the issuing of this report, however, it was noted that no significant progress had been made to reduce the fire safety risk, which included issues relating to, means of escape, compartmentation, fire detection and emergency lighting. Inspectors found during this inspection that there were inadequate measures place to audit the fire safety systems, and to monitor fire safety within the centre. No

evidence was available to indicate for example, that means of escape were being reviewed in line with the policy at the centre.

In light of the findings of this inspection, which identified issues which aligned with those in the FSRA, an urgent compliance letter was issued to the provider in the day following the inspection. This letter outlined significant risks with emergency lighting, a lack of fire drills which reflected the nature of the building, concerns with arrangements in place to detect and give warning of fires, the management of gas supply, means of escape, the overall electrical system, the kitchen extractor and staffing levels at periods of low staff number for example at night. The providers response to the urgent compliance plan did not provide adequate assurances that the high risk items listed were adequately mitigated within the allocated timeframe of one week. This meant that the risk remained elevated at the centre, and while some measures were taken to reduce some of the risk to residents, further significant action was required, including additional staffing levels until permanent measures are put in place to effectively manage the fire safety risk. This is discussed further under regulation 23: Governance and Management, and Regulation 28: Fire Precautions.

Regulation 19: Directory of residents

The directory of residents was in paper format and did not meet the criteria as set out within Schedule 3 of the regulations. For example:

- The address for the nominated contact person was not completed for two residents.
- The address for the General Practitioner was not completed in two further entries.
- There was no phone number for the General practitioner in one entry.

Judgment: Substantially compliant

Regulation 21: Records

Records required under Schedules 2, 3 & 4 were maintained in line with the regulation, stored safely and were accessible on request.

Judgment: Compliant

Regulation 22: Insurance

The designated centre had a current certificate of insurance which indicated that cover was in place against injury to residents, staff and visitors.

Judgment: Compliant

Regulation 23: Governance and management

Overall, significant improvement was required by the registered provider, to put in place effective management systems to ensure effective oversight of the quality and safety of service delivered to residents to ensure resident safety in respect of fire safety and premises.

In consideration of fire safety matters identified during inspection, the inspectors were not assured that appropriate management systems were in place to ensure the service provided was safe, appropriate, consistent and effectively monitored by the provider. For example;

- While the centre had in place a fire safety policy, the management of fire safety within the centre did not align to this policy. This was evidenced by:
    - The centre had commissioned a FSRA in 2022. This risk assessment had identified significant concerns relating to fire safety arrangements at the centre. The FSRA also outlined timelines for remedial action to mitigate the risks outlined in the FSRA. The provider had failed to implement these findings, and had not taken appropriate mitigation measures to reduce the risk as identified. The policy further outlined how the findings of the FSRA would form the basis of the fire safety risk at the centre. The policy also placed responsibility on the registered provider to implement the findings of the FSRA and review the fire precautions at the centre to reflect the findings.
    - The policy outlined a robust auditing system including daily audits of means of escape, to ensure that there were no obstructions in the event of a fire, and audits of the fire doors to ensure that the doors to resident bedrooms, compartments, and ancillary rooms were operating effectively, and would perform as expected in the event of a fire. These were not being carried out.
- Servicing arrangements to maintain the fire detection and alarm system were not robust to ensure that the detection of fires and the warning in the event of a fire, was adequate in the centre. Inspectors could not be assured that the fire alarm would be heard in all areas of the centre. This was evidenced during a bell test, which is a routine check on the alarm sound, when it became clear that the alarm was not audible within all rooms

The provider did not ensure that there were sufficient resources present at the centre to effectively manage a fire outbreak. Staffing arrangements were not sufficient to ensure that residents in all areas of the centre could be evacuated in a timely manner in the event of a fire. In the days following the inspection, the provider committed to scheduling an additional staff member to cover night shift, and to maintain fire vigilance through a series of fire safety checks.

Due to the level of risk highlighted on this inspection, the provider was issued with an urgent compliance plan the day after the inspection.The providers response to the urgent compliance plan did not provide adequate assurances that the high risk items listed were adequately mitigated within the allocated timeframe of one week. This meant that the risk remained elevated at the centre, and while some measures were taken to reduce some of the risk to residents including the allocation of an additional staff member at night time, further significant action was required.

Judgment: Not compliant

Regulation 31: Notification of incidents

The registered provider had failed to notify the Chief Inspector of Social Services of an unexpected death.

Judgment: Not compliant

Quality and safety

The inspectors found that the residents were receiving a good standard of care that supported and encouraged them to actively enjoy a good quality of life. Inspectors observed that the staff treated residents with respect and kindness throughout the inspection and that staff were committed to providing a high quality of care to residents. However, significant action was required to ensure a safe service for residents in relation to the premises and fire safety.

A selection of nursing records were reviewed on the day of inspection. Each resident had a pre assessment carried out prior to admission and a comprehensive assessment carried out within 48 hours of admission to the centre. Care plans were individualised and many clearly reflected the health and social needs of the residents.

Residents receiving end of life care had their needs and wishes respected and clearly documented in their care plans. There was access to medical services as

required. Resident's family and friends were facilitated to remain with residents at all times, in accordance with the resident's wishes.

Residents who required transfer to hospital had all relevant documents, including a nursing transfer letter sent with them. The nursing transfer letter included information on their past medical history, list of current medications and emergency contact numbers. Any changes to care were reflected in the residents care plan, on return to the centre. Transfer documents were saved to the residents file.

There was an open visiting policy and visitors were observed attending the centre throughout the inspection. However inspectors again identified that there was no appropriate private space available to residents, that was not their bedroom, for them to receive visitors in if they so wished. They registered provider had failed to action their compliance plan submitted following the last inspection in November 2023.

Inspectors reviewed the overall premises during this inspection. A resident bathroom doubled as a hairdressing space. This bathroom was on the half landing between the upper ground floor and the first floor. This arrangement impacted on the residents access to bathroom facilities when it was being used as a hairdressing area. The use of the room as a hairdressing space, also gave rise to electrical safety and fire safety concerns relating to electrical equipment being plugged into outlets on the stairs landing outside the door.

The main visitor space was within a conservatory to the rear of the centre. The space was accessed via the stairs and was located half way between the upper ground floor and the lower ground floor. This room had a single means of escape, and the layout of furniture within the room, left minimal circulation space due to the placement of furniture, and would impede evacuation in the event of a fire. The main storage space was in a building to the rear of the garden, alongside the laundry. The storage space was not sufficient for the centre as it was overstocked, and further obstructed with maintenance materials. The centre required maintenance attention, as some areas of the centre were in need of repair. A resident shower room on the lower ground floor was not usable by residents, as it was being converted into a storage room. These and other premises issues are dealt with under regulation 17: Premises.

The arrangements in place at the centre to protect residents from the risk of fire were reviewed. Residents were accommodated on all three floors, with varying dependency levels on each. This inspection found that there were inadequate measures in place to ensure that residents could be evacuated safely in a timely manner in the event of a fire.

The provider was required to make significant improvements with regard to fire safety at the centre to address the findings of their own fire risk assessment completed in 2022. Due to the level of risk associated with non-compliance's identified on this inspection, and urgent compliance plan letter was issued to the provider on the day after the inspection. The items requiring urgent action were:

- Assurances that the emergency lighting was configured to provide adequate lighting for evacuation in the event of a fire and power outage.
- The FSRA and an action plan associated with risks identified in the FSRA of 2022 was required.
- Evacuation simulations that provide assurance that "whole house evacuation" was simulated. That resident evacuation to a relative place of safety at the assembly point could be completed using appropriate evacuation aids, navigation upward over steps, and takes account of the lack of effective compartmentation.
- Assurance that was appropriately configured and maintained to ensure that the alarm could be heard from all rooms and that detection is in all places of high fire spread risk rooms.
- The ceasing of a practice of ironing items of clothing on the escape route, the removal of an installed ironing board on an escape corridor, the removal of the iron, and the clearing out of the adjacent cupboard which was not fire rated.
- The completion of a review by a competent electrician to provide assurance that the electrical system was operating within normal parameters.
- Assurance that the kitchen extract ducting was cleaned to remove any grease build up within the ducting that can result in a fire.
- A review of the staffing arrangements at times of low staff numbers, to ensure that evacuation procedures can be implemented in the event of a fire.

The providers response to the urgent compliance plan did not provide adequate assurances that the high risk items listed were adequately mitigated within the allocated timeframe of one week. This meant that the risk remained elevated at the centre, and while some measures were taken to reduce some of the risk to residents, further significant action was now required. These and further issues identified on this inspection are discussed under regulation 28: Fire Precautions.

Regulation 10: Communication difficulties

Residents with communication difficulties were assisted to communicate freely in the centre. They had access to specialist equipment and services including opthamology and audiolgy. Residents individual needs were clearly documented in care plans.

Judgment: Compliant

Regulation 11: Visits

There was no suitable private area, which is not the resident's room available to a resident to receive a visitor if required.

Judgment: Substantially compliant

Regulation 12: Personal possessions

Residents were facilitated to use and retain control over their clothes. Clothes were laundered on site and returned to each resident's wardrobes. There was adequate space available to residents to store and maintain their clothes and personal belongings.

Judgment: Compliant

Regulation 13: End of life

Care plans for resident's receiving end of life care were appropriate and individualised. They clearly identified the personal beliefs and wishes of the resident.

Judgment: Compliant

Regulation 17: Premises

Improvements were required of the registered provider to ensure that the premises is in line with the Statement of Purpose and the floor plans for which it is registered. For example:

- A resident bathroom on the lower ground floor was not available for use as a bathroom, as it was being converted into a storage space.

The registered provider, having regard to the needs of the residents at the centre, did not provide premises which conform to the matters set out in Schedule 6 of the regulations. For example:

- As there was no passenger lift in place at the centre, residents assessed as having high dependant needs living on the lower ground floor and the first floor did not have appropriate access to dining and day spaces, as all of the dining spaces were on the upper ground floor. While a chair lift was in place on one stairs, this did not provide appropriate support to high dependency residents to utilise the available day-space on other floors. The chair lift also reduced the available width of the escape stairs, which would result in restrictions to assisted movement, and evacuation.

- A section of stairs near the kitchen on the lower ground floor was in disrepair. The stairs was carpeted, which was ravelling at the corners, and a section of the steps and handrail appeared to be loose.
- There was insufficient storage available at the centre. There were two buildings in the garden, a laundry and a store room, however, both were used to store maintenance materials and timber products. The access to the stored continence wear and personal protective equipment with the storage room was obstructed by the timber sheeting. The laundry area was also used to store empty plastic containers.
- A number of areas within the centre were requiring maintenance attention. Damage was noted on some sections of walls, ceilings and skirting.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

The documentation completed for the temporary discharge of a resident to hospital was reviewed. All relevant information about the resident was sent to the receiving hospital. On return from the hospital, medical and nursing discharge letters, together with other relevant documentation was received and available for review in individual record files.

Judgment: Compliant

Regulation 28: Fire precautions

Overall significant action was required by the registered provider to ensure that residents are protected from the risk of fire.

The registered provider did not take adequate precautions against the risk of fire, and did not provide suitable fire fighting equipment for example:

- Precautions against the risk of fire were not adequate to detect gas which was used as a fuel in the kitchen and boiler rooms. While kitchen staff were in place for most of the day, there were extended periods when staff were not in the kitchen, and therefore would not be in a position to shut off the gas supply if they noticed gas. A manual shut-off procedure when the kitchen was closed, was put in place after the inspection.
- Inspectors could not be assured that the electrical system had been checked regularly by a competent electrician. Furthermore, the practice of using the bathroom on the stairs as a part-time hairdressing salon presented a fire risk, as electrical items were used in the bathroom and plugged into sockets outside. Electrical systems are a high fire risk when not maintained. The

provider engaged an electrician after the inspection to assess the condition of the system.

The registered provider did not provide adequate means of escape including emergency lighting for example:

- The emergency lighting system required review. Inspectors could not be assured that testing of the system could be carried out without adversely affecting the power supply in the areas being tested. This was evidenced on inspection when a test was being carried out on the lower ground floor emergency lighting, which resulted in a loss of power to the rest of the lower ground floor, including the kitchen, the staff areas, and resident bedrooms. Emergency lighting directional signage in some areas, was directing evacuees in directions which did not appear to provide relative safety such as the enclosed garden at the back which did not have an escape route without having to re-enter the building. Emergency lighting was not in place within any of the resident bedrooms, and some sections of escape corridor. This would make evacuation during a fire difficult when there is no natural light, and when the power goes out. There was no back-up power supply at the centre to ensure continuity of power.
- Evacuation from the lower ground floor level of the centre required the movement of residents upwards over steps. Residents on this level varied in their dependency levels with some residents requiring full assistance to evacuate. This would prove difficult in the event of a fire.
- There was a single means of escape available from the conservatory. The route was obstructed by the placement of furniture within the room. The room was not provided with a fire alarm call point.

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

- There was insufficient evidence to suggest that staff at the centre had simulated fire drills that adequately reflected the nature of the building, the limitations to escape, and the lack of compartmentation present. There was no record of a simulation of complete evacuation as outlined in the centre's fire safety risk assessment. The record of the drills which were conducted did not reflect the appropriate procedure for example:
    - Drills completed did not simulate the evacuation of all the residents in the compartment in which the fire was trialled. There was no record of vertical evacuation having been trialled. Due to the presence of stairs on every level, the trialling of evacuation to consider the movement of residents upwards over steps, would highlight the difficulties associated with having to complete this task in the event of a fire. Fire drills did not adequately reflect the dependency levels of residents present in the centre or the use of evacuation aids such as mattress evacuation sheets, stairs chair, and evacuation pads which were present in the centre, but were not being trialled during evacuation

drills.This meant that inspectors could not be assured that staff were familiar with the method of evacuating residents with reduced mobility in a timely manner.

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

- The centre was equipped with a category L2/L3 fire detection and alarm system. This was contrary to their own policy at the centre which indicated a category L1 system would be present. Inspectors could not be assured that there was appropriate detection in place within all rooms including the attic spaces, an office on the stairs half landing, a lower ground floor sluice room, the conservatory day space, storage rooms throughout the centre, and some sections of corridor.

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

- Assurance was required in respect of the compartmentation within the building. Compartment walls, which should provide a minimum of one hour of fire protection, did not appear to be constructed of fire rated materials consistent with the fire rating in places. This included spaces in the walls that were used as alcoves for shelving. The construction of the wall in these areas appeared to reduce the effective fire rating of the wall. This was present along some escape routes, and stairwells.
- Assurance was required in respect of the fire rating of the floors, or ceilings within the escape routes. This meant that evacuation using the corridors would not provide the expected level of protection from a fire if not fire rated, and would not restrict the spread of fire, smoke and fumes through the compartment lines to other areas of the centre.
- Fire doors throughout the centre required a review. Compartment doors, ancillary room doors and bedroom doors on all three floors did not have the characteristics of fire rated doors such as fire rated hinges or handles, had excessive gapping around the perimeter and were fitted with a wooden floor threshold. A full assessment of the fire doors and their suitability was required.
- Attic hatches did not appear to be fire rated within the centre. Attic hatches were present on the first floor, with one bedroom having an attic hatch inside. Non fire rated attic hatches would allow fire smoke and fumes to spread through the attic space to the room below.
- There were storage spaces in use under both stairwells on the lower ground floor. The storage space did not appear to be constructed of fire rated materials or have fire rated doors installed. These store rooms were used for combustible and flammable materials such as toiletries, aerosols and paper products.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Care plans were individualised and reflective of the health and social care needs of the resident. They were updated quarterly and sooner if required. Care plans demonstrated consultation with the residents and where appropriate their family.

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 19: Directory of residents	Substantially compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Substantially compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant

Compliance Plan for Aclare House Nursing Home OSV-0000001

Inspection ID: MON-0041154

Date of inspection: 01/10/2024

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: All the entries in the directory have been reviewed and completed with all required information as set out in schedule 3.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: We have engaged with a fire consultant. Fire detection and alarm system. - The necessary compliant cabling is being installed. A new service company has been engaged. Emergency lighting and escape signage – All emergency lighting and escape signage have been installed on designated escape routes, with additional installation planned for high-risk areas throughout the building. Fire detection and alarm system is being upgraded to include a new sound bell system. Additional staff have been added to night duty while work is been completed. Extra fire extinguishers have been added.	
Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents: All notifications will be informed to authorities in a timely manner.	
Regulation 11: Visits	Substantially Compliant
Outline how you are going to come into compliance with Regulation 11: Visits: We are looking to install an area beside the conservatory for visiting.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • Will update Statement of Purpose and Floor plans to reflect the same. • All residents are accommodated according to their needs in the nursing home, ski pads have been acquired and staff have been trained in their use. Residents can be accommodated on the stairs with the chair lift in the event of an evacuation. • The section of stairs near the kitchen will be repaired after all fireworks have been completed. • Maintenance material have been removed from the laundry and store room and being kept in the maintenance shed. • Areas which require maintenance will be repaired after all the fireworks have been completed.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • Diskin Fire has installed the system to connect the automatic shut of valve to the alarm system. Walls Mechanicals Services limited are waiting the delivery of the automatic shut off valve and will install as soon as it is delivered. • A competent electrician has been engaged and has been completing works on the electrical system. The practice of using the hairdressing chair has been ceased. • All emergency lighting and escape signage have been installed on designated escape routes, with additional installations planned for high-risk areas throughout the building.	

Following the fire detection and alarm system upgrade, further lighting installations will commence then.
• Formal fire safety training has been completed, and four fire drills have been conducted. Six staff members will remain on duty until fire work is completed

• All under stairs areas identified as store rooms have been cleared and all storage removed, as they were never intended to be used for storage - They have been designated 'not for storage use'.
• Diskin Fire has installed, completed and commissioned a new Category L1 fire detection and alarm system to include the whole house, including conservatory, office and attic.
• Formal fire safety training has been completed, and four fire drills have been conducted. Additional staff members will remain on duty. Additional fire drills will be scheduled once the fire detection and alarm system are fully operational.

• Diskin Fire has installed, completed and commissioned a new Category L1 fire detection and alarm system to include the whole house, including conservatory, office and attic.
• Fire doors Ireland have informed us that they will start on 02/12/24 by dividing all the floors into three compartments that will enhance fire containment and facilitate progressive horizontal evacuation, by installing 60/30 fire curtain within the attic void. An AOV will be connected to the fire alarm system. Where brand new doors are required, they will be constructed to BS 476: Part 22:1987, Section 7 of BS 8214:2016.

• All stored materials under stairwells have been removed.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

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)(b)	The person in charge shall ensure that having regard to the number of residents and needs of each resident, suitable communal facilities are available for a resident to receive a visitor, and, in so far as is practicable, a suitable private area, which is not the resident's room, is available to a resident to receive a visitor if required.	Substantially Compliant	Yellow	31/01/2025
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with	Substantially Compliant	Yellow	28/12/2024

	the statement of purpose prepared under Regulation 3.			
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	15/10/2024
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	14/10/2024
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/11/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Red	09/10/2024
Regulation 28(1)(a)	The registered provider shall take adequate precautions	Not Compliant	Red	30/03/2025

	against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Red	13/11/2024
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Red	13/11/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	13/11/2024
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the	Not Compliant	Red	16/10/2024

	designated centre and safe placement of residents.			
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	02/10/2024