Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Ashbury Nursing Home
Name of provider:	A N H Healthcare Limited
Address of centre:	1A Kill Lane, Kill O'The Grange, Blackrock, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	18 January 2024
Centre ID:	OSV-0000007
Fieldwork ID:	MON-0042612

About the designated centre

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

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	88

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
Thursday 18 January 2024	09:05hrs to 18:00hrs	Frank Barrett	Lead
Thursday 18 January 2024	09:05hrs to 18:00hrs	Kathryn Hanly	Support

What residents told us and what inspectors observed

There was a relaxed atmosphere within the centre as evidenced by residents moving freely and unrestricted throughout the centre. The centre was warm and homely. Inspectors spoke with nine residents living in the centre. All were very complimentary in their feedback and expressed satisfaction about the standard of care provided.

Visitors were observed attending the centre on the day of the inspection. Inspectors spoke with two family members who were visiting. Visitors spoken to were very complementary of the staff and the care that their family members received. Visitors confirmed that they could call to the centre anytime.

Residents appeared to be relaxed and enjoying being in the company of staff. All interactions were observed to be respectful towards residents. Those residents who could not communicate their needs appeared comfortable and content.

There was a varied programme of activities provided seven days a week. Activities were facilitated by activity co-ordinators, nursing and care staff and were tailored to suit the expressed preferences of residents. Inspectors observed mass taking place in the sitting room of the Grange wing on the afternoon of the inspection. Other activities included flower arranging, exercise classes, music and arts and craft. External outings and day trips were also facilitated using the centres mini bus.

The location, design and layout of the centre was generally suitable for its stated purpose and met residents' individual and collective needs. Ashbury Private Nursing Home is registered for 97 beds and is divided in to two units; an original period building known as the Main House and a newer wing known as the Grange Wing. A link corridor joins the two units. The provider had removed one bed from each of the five multi-occupancy rooms. This work was part of the centre's plan to to optimise the bedroom layout to support residents' right to privacy and dignity and to meet the centre's condition 4 of registration, which required the provider to renovate and reconfigure or reduce the occupancy of these rooms in order to meet the requirements of the health act SI 293 2016 and the National Standards for Residential Care Settings for Older People in Ireland 2016. Reconfiguration of a further bedroom was also planned, with one further bed being removed by 31st of January.

Residents were supported to personalise their bedrooms, with items such as photographs and artwork. There were appropriate handrails and grab-rails available in the bathrooms and along the corridors to maintain residents' safety. There was adequate communal space including sitting rooms and dining rooms for residents in each part of the centre. The external courtyards were well-maintained and provided enclosed safe spaces for residents' use.

Overall, the general environment including residents' bedrooms, communal areas and toilets appeared visibly clean. Equipment viewed was also visibly clean. However, the décor including flooring in some parts of the main house was showing signs of minor wear and tear. The provider was endeavouring to improve existing facilities and physical infrastructure at the centre through ongoing maintenance and painting.

While the centre generally provided a homely environment for residents, improvements were required in respect of premises and infection prevention and control, which are interdependent. For example, there was a lack of appropriate storage space in the centre resulting in the inappropriate storage of moving and handling slings and incontinence wear within a communal bathroom in the main house. Details of issues identified are set out under regulation 27 Infection prevention and control, and regulation 17 premises.

Storage concerns were also impacting on fire precautions at the centre. Inspectors saw hoists and other equipment stored in a disabled refuge area at the entrance to a stairs. this area had a sign fixed to the wall which read "hoist storage area". Furniture and filing cabinets were also obstructing a door at a nurses station. These issues are highlighted further under regulation 28 fire precautions and regulation 17 premises.

Some of the ancillary facilities including the equipment cleaning room and the sluice rooms did not support effective infection prevention and control. The hand washing sink in one sluice was obstructed by a shower and equipment washing sinks were not available in the sluice rooms. Details of issues identified are set out under regulation 27.

Staff had access to a dedicated housekeeping room for storage and preparation of cleaning trolleys and equipment and a sluice room for the reprocessing of bedpans, urinals and commodes. These areas were well-ventilated, clean and tidy. Household staff detailed a good understanding of cleaning processes and chemicals used for environmental hygiene.

However, inspectors were informed that alcohol wipes were used by nurses and healthcare assistants for cleaning equipment including mattresses. Alcohol wipes are only effective when used to disinfect already "clean" non-porous hard surfaces. Furthermore alcohol wipes can damage equipment with prolonged use. Findings in this regard are presented under regulation 27.

Barriers to effective hand hygiene practice were also observed during the course of this inspection. For example, hand wash sinks in sluice rooms and on corridors did not support effective hand hygiene. Three sinks were dual purpose, used for hand hygiene and for drinking water. This may lead to cross infection. The provider informed inspectors that additional clinical hand washing sinks had been ordered and were scheduled for delivery on 23 January 2024.

The provider had implemented measures to improve fire safety throughout the centre, including the provision of a "staff Fire Information Handbook", which outlined the nature of the centre in terms of layout and evacuation. This booklet

was freely available in corridoors, and was an innovative tool for staff to refresh their understanding of fire safety at the centre. Staff spoken to on the day of inspection were very knowledgeable of the evacuation procedures, and the use of various routes to safety. Inspectors noted thast there were some areas where evacuation of residents would require evacuees to travel up some steps. Further fire safety issues are discussed under regulation 28 fire precautions.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

The registered provider had failed to ensure there were management systems in place to ensure that the service provided was safe and appropriate. Inspectors found that the provider did not comply with Regulation 23: governance and management and Regulation 27:Infection Control and Regulation 28: Fire Precautions. The provider generally met the requirements of regulation 17: Premises but some action was required to be fully compliant.

ANH Healthcare Limited is the registered provider for Ashbury Private Nursing Home. This is a family owned business, with family members holding many of the senior nursing and operational management positions in the centre. There was an established and clearly defined management structure in place that identified lines of authority and accountability.

The provider had nominated a nurse manager to the role of infection prevention and control lead and link practitioner. However, this person had not yet completed the required link practitioner training to support staff to implement effective infection prevention and control and antimicrobial stewardship practices within the centre.

The provider had access to diagnostic microbiology laboratory services and a review of resident files found that clinical samples for culture and sensitivity were sent for laboratory analysis as required. Copies of laboratory reports were filed in resident's healthcare records.

Records of residents with previously identified multi-drug resistant organism (MDRO) colonization (surveillance) was recorded on monthly quality monitoring and data reports. However a review of acute hospital discharge letters and laboratory reports in 45 resident files found that staff had failed to identify a significant number of residents that were colonised with MDROs. As a result accurate information was not recorded in a small number of resident care plans and appropriate infection control and antimicrobial stewardship measures may not have been in place when caring for these residents.

The overall antimicrobial stewardship programme also needed to be further developed, strengthened and supported in order to progress. For example, antibiotic consumption data was not routinely analysed and used to inform infection prevention practices. Findings in this regard are presented under regulation 23.

Regular infection prevention and control audits were undertaken. An infection prevention and control audit undertaken in August 2023 achieved 100%. However, a review of the audit report found disparities with 17 of the 71 criteria audited. For example, contrary to findings on the day of the inspection, the audit found that equipment was safely and effectively decontaminated in line with best practice guidelines. The audit also found that hand hygiene facilities were in line with best practice and national guidelines.

Efforts to integrate infection prevention and control guidelines into practice were underpinned by mandatory infection prevention and control education and training. A review of training records indicated that the majority of staff were up to date with mandatory infection prevention and control training. However, inspectors identified through talking with staff, that further training was required to ensure staff are knowledgeable and competent in the management of residents colonised with MDROs.

Inspectors noted issues relating to the management of fire safety at the centre. While fire drills were being carried out weekly, it was not clear from the record where fire drills had taken place. The number and means of resident evacuation was not recorded, contrary to policy at the centre.

Weekly audits and fire safety checks on means of escape, containment and fire prevention were being completed but were not identifying areas of concern as highlighted on the day of inspection. Issues highlighted relating to obstructions on means of escape, were not being picked up in these audits. Stair gates fixed to stairs, had not been identified as a risk for evacuation in the event of a fire. The impact of having these gates on escape routes had not been risk assessed by the provider. The provider submitted a risk assessment of the stair gates in the days following the inspection. Issues relating to the management of fire safety are detailed under regulation 23 Governance and Management, and further fire safety issues are detailed under regulation 28 fire precautions.

Regulation 23: Governance and management

Overall, 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

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;

- Daily Fire safety checks of the escape routes were not identifying areas of concern, for example, stair gates fitted to stair landings were obstructing the means of escape, or hoists stored on stair landings, which was a repeat finding from inspections of the centre. No risk assessment of the impact of these practices on the evacuation of residents in the event of a fire was available on the day of inspection.
- Fire prevention audits were not identifying storage issues which impacted on fire safety, for example, where flammable items such as paint and aerosols were stored in a high fire risk area of an electrical cabinet on the ground floor.
- Inspectors could not be assured that fire doors throughout the centre which had been reviewed by a competent person, had been remediated.These fire doors had stickers fitted to them which identified the door and the fire rating, however, inspectors could not be assured that they would contain fire fumes and smoke in the event of a fire as per the fire rating. These and further fire safety issues are also discussed under regulation 28 fire precautions.

Infection prevention and control and antimicrobial stewardship governance arrangements did not ensure the sustainable delivery of safe and effective infection prevention and control and antimicrobial stewardship. For example;

- Disparities between the findings of local infection prevention and control audits and the observations on the day of the inspection indicated that there were insufficient assurance mechanisms in place to reach compliance with the National Standards for infection prevention and control in community services.
- Management and staff were unaware of which residents were colonised with MDROs. Lack of awareness meant that appropriate precautions may not have been in place to prevent the spread of the MDROs within the centre.
- There was no evidence of ongoing a targeted multidisciplinary antimicrobial stewardship programme or quality improvement initiatives. This impacted the overall quality of antibiotic use within the centre and may contribute to antimicrobial resistance, clostridioides difficile infection and other side effects.

Judgment: Not compliant

Quality and safety

Overall, improvement was required in the upkeep of the facilities and premises. A bathroom area on the second floor required attention as it was in a poor state of repair. The provider had a plan in place to address this, but could not give details on when this would be carried out.Other areas required attention to maintain and

upgrade the overall condition of the centre, for example, a ground floor toilet which had damaged walls, and some doors throughout the centre. Several examples of storage concerns were identified during inspection, some of which impacted on fire safety

Inspectors reviewed procedures in place to protect residents in the event of a fire. The centre was equipped with a category L1 fire detection and alarm system. However, inspector's noted that the fire alarm annual certificate was not available on the day of inspection. Inspectors noted that escape routes in some areas were obstructed by stair gates and furniture in other areas. There were personal emergency evacuation procedures (PEEPs) in place for each resident, with colour coded stickers used to identify the dependency of each resident. Inspectors noted that in some cases numerous stickers were fixed above the bed of residents, which were contradictory. This could lead to confusion during evacuation. Emergency lighting directional signage was in place throughout the centre, however, in some cases, the directional signage was a sticker without a light. This would not illuminate the escape route in the event of a fire and a power loss.

During the inspection, inspectors were not assured of the effective compartmentation within the centre. Issues were noted with fire doors throughout. These issues included; non fire rated ironmongery, missing smoke seals, and damaged doors which may not contain fire and smoke in the event of a fire. Further containment issues were identified in the electrical and communications area of the ground floor, as well an electrical distribution room on the second floor. The provider had a plan to remediate these issues, but was not in possession of a time frame for starting or completing the works.

The provider continued to manage the ongoing risk of infection while protecting and respecting the rights of residents to maintain meaningful relationships with people who are important to them. Residents were observed to receive visitors throughout the day.

Inspectors identified some examples of good practice in the prevention and control of infection. Staff working in the centre had managed a small number of outbreaks and isolated cases of COVID-19 over the course of the pandemic. A review of notifications submitted to HIQA found that outbreaks were generally managed, controlled and documented in a timely and effective manner. Staff spoken with were knowledgeable of the signs and symptoms of COVID-19 and knew how and when to report any concerns regarding a resident.

At the time of the inspection there was increased community transmission of respiratory viral infections. Following a risk assessment, staff were instructed to wear surgical masks while delivering care to residents. There was adequate access to personal protective equipment (PPE) and staff were observe to consistently wear PPE in line with national and local guidelines.

The laundry service had been outsourced to an external company. Laundry was segregated in line with best practice guidelines. However, inspectors observed an

open trolley containing clean linen in an outside area. This posed a risk of contamination.

Equipment viewed was generally clean. However, oversight of clean and sterile supplies required improvement. Several products including intravenous fluids, alcohol hand gel and tubs of chlorine tablets has passed their expiry date. Findings in this regard are presented under regulation 27.

Regulation 17: Premises

Improvement was required having regard to the needs of the residents at the centre, to provide premises which conform to the matters set out in Schedule 6 of the regulations. For example:

- Some areas of the premises required maintenance attention internally:
    - A floor in a bathroom on the second floor was in poor structural condition. There was a section of flooring which had been removed, and stuck back down with duct tape.
    - A first floor toilet near the lift had damaged wall covering and skirting. The window in this toilet was not closing fully, and the door could not be locked.
    - Some doors in the centre required maintenance attention. Lounge room doors had damaged paintwork, and some pieces of timber missing.
- Storage concerns were noted during the inspection for example:
    - The storage of disused mobility equipment and furniture in a first floor toilet. Hoists in use at the centre, were stored in escape route refuge spaces.
    - Inappropriate storage of flammable and combustible items in the electrical and communication room on the ground floor.
    - Inappropriate storage of moving and handling slings and incontinence wear within a communal bathroom in the main house.

Judgment: Substantially compliant

Regulation 27: Infection control

Equipment and the environment was not managed in a way that minimised the risk of transmitting a healthcare-associated infection. This was evidenced by;

- One sluice room and an equipment cleaning room contained a shower for washing equipment. The use of a shower hose may lead to environmental contamination and the spread of MDRO colonisation.

- The expiry date displayed on the containers of the bed pan washer detergents in three sluice rooms had passed. The provider clarified that the detergent had been decanted from another container. This posed a risk of cross contamination.
- Tubs of 70% alcohol wipes were inappropriately used throughout the centre for cleaning resident equipment including mattresses. Alcohol wipes are only effective when used to disinfect already "clean" non-porous hard surfaces. Furthermore alcohol wipes can damage equipment with prolonged use. For example, the covers of several mattress were damaged and worn.
- Hand hygiene facilities were not in line with best practice and national guidelines. Wall-mounted liquid soap dispensers throughout the centre were refilled from a bulk container. This practice posed a risk of cross-contamination. A hand washing sink with one sluice room was not accessible. This may lead to poor compliance with hand hygiene.
- Several products had passed their expiry date including bags of normal saline for infusion, tubs of chlorine tablets and some bottles of alcohol hand gel. This may have impacted the sterility and efficacy of these products.

Judgment: Not compliant

Regulation 28: Fire precautions

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

- High fire risk areas including the ground floor electrical cabinet and communications room, had maintenance items stored. The communications side of this room had a large amount of items plugged into sockets, and cabling which was not organised to minimise the risk of fire.
- A nurses station had a disused, expired and depressurized Oxygen cylinder stored within. Staff at the centre were not aware that this item was present in the room. This was removed on the day of inspection. There was no appropriate controls in place or signage to indicate the presence of oxygen storage in this room.

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

- Escape routes were obstructed in some areas, by stair gates. There was no risk assessment available to asses the impact of stair gates on escape routes during an evacuation. An exit door from the nurses station was partially obstructed by medication trollies and other pieces of furniture.
- Furniture was partially blocking escape routes from some bedrooms near the fish tank. This area was an escape route for a number of residents, and would present challenges in the event of an evacuation.

- Emergency lighting directional signage was not in place in some areas, such as the first floor lounge area, and the use of stickers on the walls indicating the evacuation direction was noted at the nurses station and the main porch on the first floor. This was noted as an evacuation route and emergency exit door on the layout plans on the walls.

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:

- Fire drills were carried out weekly at the centre, however, inspectors could not be assured that vertical evacuation had been trialled on the various escape stairs. Staff were knowledgeable of evacuation, however, inconsistencies presented in the escape routes such as a primary escape route from an area on the second floor, which required evacuees to travel upwards over seven steps. One resident in this area was not independently mobile, and this route was not trialled in fire drills. Fire drills did not record the time taken to evacuate the largest compartment under periods of low staffing numbers. This meant the inspectors could not be assured that staff had practiced evacuation of all areas under low staffing number for example at night.

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

- Fire detectors were not in place in some areas of the centre including a second floor electrical distribution room, and under stairs store at reception, under stairs store in the staff changing area, toilet 32, and under stairs store in the grange wing.
- Containment of fire and smoke was compromised at the electrical cupboard on the ground floor. A door from the corridor lead to an internal lobby, where there was an electrical cabinet on the right, and a communications room on the left. There was extensive amounts of maintenance material stored in a cabinet between the two rooms. There was no door on the communications side, and a door which had been fitted on the electrical side did not appear to have fire sealing around the perimeter. The maintenance materials were stored behind non-fire rated doors, and there were unsealed service penetrations within the communications room.
- Containment issues were noted in doors at the centre, for example, large gapping around the perimeter, and underneath doors, non fire-rated ironmongery, and door closers not operating correctly. This included some bedroom doors, and compartment doors. Some fire doors were damaged which would impact on the fire resistance of the door, and compartmentation could not be assured in some areas as door frames did not appear to be fire sealed around the frames.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant

Compliance Plan for Ashbury Nursing Home OSV-0000007

Inspection ID: MON-0042612

Date of inspection: 18/01/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Our environmental fire audit now includes inspection of all storage areas on a weekly basis to ascertain if the practice of storing combustible items has ceased. A full review of every resident's medical file has taken place to ensure that every staff member is fully aware of every residents colonisation and infection status. An awareness campaign among all nurses has commenced in relation to the importance of antimicrobial stewardship. All nurses have completed the required training in this regard. An antimicrobial monthly register is now in place and discussed at the monthly IPC clinical governance meetings.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The schedule of maintenance and repairs includes the requirement for the bathroom floor to be repaired. The PVC cladding has been replaced on the bathroom wall. Inappropriate storage of hoist slings has been discontinued from the bathroom storage. The inappropriate storage of items has been included in our environmental fire audit and is monitored on a weekly basis.	

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
5 clinical hand wash sinks have been purchased and installed. Access to the hand washing sink in the sluice room has been rectified. The position of the sink has been moved.

Single use only detergent for the bed pan washers has been purchased. The practice of refilling same has ceased. Furthermore, all soap dispensers and alcohol gel dispensers are single use only.

All alcohol wipes have been removed from the building and the purchase of same has stopped.

An audit has been undertaken of all stock to ensure that any out-of-date products have been removed and this will continue to be monitored on a monthly basis and the practice of stock rotation is ongoing.

The equipment cleaning rooms and sluice room will be refurbished in order to ensure that the risk of spread of MDROs during the cleaning of equipment is minimised.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The inappropriate storage of items is reviewed weekly as per previous comment in respect of weekly environmental audit.

The oxygen cylinder was removed on the day of the inspection.

Cabling in the Comms room has since been reviewed and organised accordingly.

Our fire drill reports have been updated to include a more comprehensive detail of the efficacy of each drill including length of time of drill on different staffing levels and the rotation of each compartment for drills including those on minimum staffing levels.

Our most recent fire training included fire evacuation drills in both horizontal and vertical evacuations. The vertical drills took place from 2 bedrooms where a vertical evacuation up a small section of steps is the primary evacuation route for two residents.

The duct in between the comms room and the external wall of the building has since

been fire stopped.
A stair gate risk assessment in respect of fire evacuation was submitted to the inspector on the day following the inspection by email. This risk assessment is now in place in our risk register and is scored as a LOW RISK. There is currently one stair gate in place which is very easily opened in any course of activity, including by the residents themselves. The gate acts as a deterrent for one resident who likes to mobilise in the area of the 3 steps from which it protects against from using unaided.

The Storage of equipment in the area beside the nursing station has ceased and is now stored in an alternative area, which does not pose any threat to an evacuation.

The seating, which had previously been used by residents as a place of relaxation in the vicinity of the fish tank area has been removed.

Emergency lighting and directional signage: Our fire consultant is undertaking a full review of emergency lighting and directional signage in the specific areas noted in the inspection, and once we have the completed review, we will implement any required updates to signage / emergency lighting.

Fire Detectors: Our fire consultant is undertaking a full review of fire detection in the specific areas noted in the inspection, and once we have the completed review, we will implement any required updates to signage / emergency lighting.

Containment of smoke in one electrical communications area:
This entire compartment has been re-slabbed with fire proofed slabbing, ensuring that the full compartment is fully fire proofed.

All maintenance equipment was removed on the day of the inspection.
Fire doors have been put in place. The entire area has been re-slabbed with fire proofed slabbing.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/04/2024
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	Orange	05/03/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare	Not Compliant	Orange	30/04/2024

	associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	30/04/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/04/2024
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	Orange	05/03/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting,	Not Compliant	Orange	30/04/2024

	containing and extinguishing fires.			