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:	Ashley Lodge Nursing Home
Name of provider:	Ashley Lodge Nursing Home Limited
Address of centre:	Tully East, Kildare, Kildare
Type of inspection:	Unannounced
Date of inspection:	01 August 2024
Centre ID:	OSV-0000009
Fieldwork ID:	MON-0044450

About the designated centre

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

Ashley Lodge is a single-storey purpose-built centre situated on the outskirts of Kildare town. The centre can accommodate 55 residents, both male and female, for long-term and short-term stays. Care can be provided for adults over the age of 18 years but primarily for adults over the age of 65 years. 24-hour nursing care is provided. Residents' accommodation is arranged over three wings which meet at the reception and communal rooms. Residents' bedroom accommodation comprises 41 single and seven twin bedrooms, the majority have en-suite facilities. Communal accommodation includes a sitting room, a dining room, a sun room and a visitors' room.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	54

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 1 August 2024	10:40hrs to 18:00hrs	Niall Whelton	Lead

What residents told us and what inspectors observed

Ashley Lodge Nursing Home is located in a rural setting approximately three kilometres from Kildare town. It is within a single storey building, comprising of three corridors of bedrooms, leading to a central entrance area with communal spaces and ancillary areas such as the kitchen, staff facilities and administration offices. The centre is registered to accommodate 55 residents, with 54 residents living in the centre on the day of inspection.

The inspector was met by the assistant director of nursing (ADON), who facilitated the inspection. This inspection included a focused review of the premises and fire precautions.

There was a pleasant atmosphere in the centre. Most residents were up and about and were seen moving around the centre unrestricted and had access to all communal spaces where they enjoyed various activities. In the afternoon, mass was held for residents in the main day room. Staff were seen assisting residents in a patient and kind manner and did not hurry them. There was a small secure garden to the rear. The weather was fine on the day of inspection and sun cream was available; residents were using the outdoor space and enjoying its facilities. There was outdoor an dining set and seating with plenty of plants and flowers in bloom. In this area, there was a residents smoking area and a greenhouse. There were a number of sunflowers which the residents had grown. The inspector spoke with residents and they relayed that they enjoyed the outdoor space. The door to the outdoor space had a short steep ramp at the door threshold, restricting independent manoeuvrability through the door if using certain mobility aids or a wheelchair. There was also a small man-made lake to the front of the centre, with seating available for residents and their visitors to enjoy.

At a previous inspection, a resident's hair salon had been converted to a staff room, removing this facility for residents. The provider had committed to reinstate the hair salon and had made arrangements for an external building to be constructed as a staff room. This was under construction and and was nearing completion. The hair salon had not yet been reinstated, and was awaiting the completion of the external staff room.

The central bedroom corridor had a two bedded room and a single room which did not have an ensuite. There were no toilet or shower facilities on this corridor for those residents; they were required to go to another corridor via the homes entrance area.

The inspector saw the fire doors to bedrooms were fitted with a device to enable the resident to have their door open, but would shut on activation of the fire alarm to prevent the spread of fire and smoke. Escape routes were seen to be clear and unobstructed.

The inspector observed two bedrooms which were being painted.

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

This unannounced single day inspection was carried out to monitor compliance with the regulations made under the Health Act 2007 (as amended) and to inform decision making regarding the renewal of the registration for the designated centre. The inspector also followed up on the progress made by the provider to address issues with the premises and fire precautions.

The findings of this inspection were that, while the provider had taken action to improve fire containment and oversight of fire safety in the centre and the upkeep of the premises, further action was required in relation to regulation 17 premises and regulation 28 fire precautions.

Ashley Lodge Nursing Home Limited was the registered provider for Ashley Lodge Nursing Home. The centre is part of a wider group of nursing homes in Ireland. There was a clear management structure in place. The clinical management of the centre was led by the person in charge (PIC) who was supported by an assistant director of nursing, clinical nurse manager and a team of nursing, care, maintenance, kitchen and administrative staff.

The provider had arranged for a fire safety risk assessment by an external fire safety consultant in November 2021. At the previous inspection in March of this year, there had been a lack of progress to address, and insufficient oversight of, known fire safety risks. At this inspection, the inspector noted significant progress in addressing those risks. The provider had submitted an action plan which indicated all actions were complete and closed out. This had not been issued by the competent person and the inspector found some actions which were still not adequately addressed. The provider is required to submit a time bound action plan for any outstanding risks and when the work is complete, to submit appropriate sign off from the competent person to confirm all actions in the fire safety risk assessment have been addressed.

In relation to the premises, the provider was not meeting the requirements of the national standards in relation to the amount of communal space available and sanitary facilities on one bedroom corridor. This is explored further under the quality and safety section of this report.

Regulation 23: Governance and management

The management systems in place were not sufficiently robust to ensure the service provided is safe, appropriate, consistent and effectively monitored, for example:

- While the fire safety risk assessment indicated all actions were closed out, the inspector identified a number of those risks which were not adequately addressed. The provider is required to submit a time bound action plan for any outstanding risks and when the work is complete, to submit appropriate sign off from the competent person to confirm all actions in the fire safety risk assessment have been addressed
- The provider is required to submit the structural report which assessed the settlement cracks in the building. This was not available for review during the inspection
- The communal space available to residents did not meet the standard of 4 square metres per resident as set out in the national standards
- The provision of toilets and showers on the central corridor, for residents who do not have ensuite facilities, was not adequate to protect their privacy and dignity as they were not in close proximity to their private space
- Some schedule 3 records were not securely stored and were stored in an unlocked admin store and contained confidential information

Judgment: Not compliant

Quality and safety

Overall, the inspector found that significant progress had been made to address previously identified fire safety risks, however this inspection identified further risk which requires action and this is explored further in regulation 28 fire precautions.

In the central bedroom corridor, a two bedded room and a single room did not have ensuites and relied on the shared bathroom facilities. There was no communal toilet or shower/bath on this corridor and residents were required to circulate through the main entrance area and communal area to reach a toilet or shower; this did not ensure the residents privacy and dignity was maintained.

The inspector reviewed the communal space available for residents, which comprised a dining room, day room, library and sun room. When all communal space was collated, it did not meet the a minimum of 4 square metres for each resident as set out in the national standards.

The inspector noted a number of settlement cracks in some walls and floors. In one location, this resulted in the floor covering being torn. There was also a notable slope on the corridor floor at these locations. The provider confirmed there was a

structural report and would submit this to the chief inspector. It was not available for review during the inspection.

The provider had implemented a maintenance tracking system; this consisted of an app on a tablet which uploaded a photograph of the issue and assigned a level of urgency. This was available to management and maintenance staff.

The inspectors reviewed the fire safety management practices in place, including the physical fire safety features of the building. The inspector also examined records for maintenance, fire safety training of staff, evacuation procedures and the programme of drills.

The building was sub-divided into fire compartments to facilitate horizontal evacuation. The compartments were highlighted on floor plans displayed by the fire alarm panel. The evacuation floor plans had been updated, but were waiting to be mounted. It was confirmed to the inspector that they would be mounted in the days following the inspection

Since the previous inspection, extensive work was completed by external contractors to improve measures in place to contain fire. An external fire sealing contractor had completed fire sealing work; fire compartment boundaries in the attics had been sealed and there was documentation on file to verify this.

Furthermore, a number of fire doors had been replaced and there had been remedial work to fire door to address deficits. Notwithstanding this, the inspector saw some doors that didn't close effectively and noticed that in general bedroom doors did not have a smoke seal to prevent the uncontrolled spread of smoke to escape routes.

On one bedroom corridor, fire compartment doors had been replaced with new sixty minute fire rated doors. The fire compartment boundaries on the other bedroom corridors had thirty minute fire rated doors, and would not provide sufficient protection to support the adopted progressive horizontal evacuation strategy.

Drill records reviewed showed that the drills had simulated the evacuation of the largest fire compartment with night time staffing levels. The simulation included the time taken to reach and read the fire alarm panel. The inspector also spoke to staff and discussed the procedure to follow in the event of a fire. The staff spoken with were very knowledgeable and gave consistent responses about the evacuation strategy. Staff also told the inspector that the fire warden was identified for each shift on the staff roster; the inspector saw the roster and confirmed this.

The inspector noted that the centre was provided with emergency lighting, fire fighting equipment and a fire detection and alarm system throughout. Records showed that they were serviced at the appropriate intervals. While the fire alarm system was a classified as an appropriate L1 fire detection and alarm system, a number of areas were not fitted with detection where required.

Regulation 17: Premises

Action was required to ensure compliance with regulation 17 and Schedule 6:

- Toilet, washing and bathing facilities were not provided for residents who lived in bedrooms without ensuites on the central corridor, in a dignified manner as they were not in close proximity to their private accommodation. Residents were required to circulate from their bedroom through the entrance foyer to reach a toilet or shower.
- Upon review of the amount of communal space, there was insufficient communal space for residents in the designated centre as the communal space available did not meet the 4 square metres per resident as set out in the national standards
- There were settlement defects on two of the bedroom corridors, presenting as cracks on walls and floors. There had been a structural report completed, but this was not available in the centre and the provider committed to submitting it to the chief inspector post inspection.
- Cracks in the floor resulted in damage to the floor covering.
- A toilet near the kitchen was not adequately ventilated and had a malodour
- There was a step at the door leading to the secure garden. This consisted of a timber short ramp, however it did not afford independent access and required review.
- The storage arrangements in the centre were not adequate. The file store was small and was full, with boxes on the ground and shelves.

Judgment: Not compliant

Regulation 28: Fire precautions

Works had been completed in the centre to address fire safety risks identified in the providers own fire safety risk assessment. While significant work was completed, further action was required by the provider to comply with the regulations.

Improvements were required by the provider to ensure adequate precautions against the risk of fire and for reviewing fire precautions:

- The small room behind reception contained an electrical fuse board; risk assessment by a competent person is required to determine appropriate controls for staff to follow in relation to storage in this area. There were cardboard boxes in front of the panel and file boxes adjacent on shelves. The provider assured these would be moved on the day of inspection.
- The aforementioned room also housed the fire alarm panel, which was remote from the main entrance. In order to get to the fire alarm panel, staff were required to unlock the door to reception and the door to admin store, which may cause delays in an emergency.

- The signage to some fire doors was incorrect, and did not align with the door type. For example, a fire door with an appropriate hold open device had a sign indicating to keep door shut.

The arrangements for providing adequate means of escape including emergency lighting were not effective:

- External escape routes were not adequate. They consisted of a concrete pathway following the line of the building, some of which led to a gravel track around the building; these routes would not be conducive for mobility or evacuation aids.
- The threshold to some exits was high. This meant that egress may be hindered where mobility aids and evacuation aids were used.
- the provision of exit signage was not adequate; in some areas, exit signs were not visible to guide occupants towards the exit. Some cross corridor doors did not have an exit sign in both directions of escape.
- There was one bedroom adjacent to the kitchen; assurance was required that the kitchen was adequately contained from this bedroom and escape corridor to ensure an effective means of escape for this room.
- The certificate/confirmation for annual inspection and testing of the emergency lighting was not available for review. Instead, there was a report issued indicating a number of failed emergency lighting units. Assurance is required from the provider that these failed units have been repaired and appropriate paperwork issued to verify.

The measures in place to detect and contain fire were not effective, for example;

- the shower in the male changing room was being used as a locker room and required fire detection. In addition, fire detection was missing from a sluice room, kitchen store and some small stores.
- Deficits to fire doors were impacting the containment measures in the centre. In particular, the door to the laundry room, a room of increased fire risk, contained gaps. Assurance was required from the provider, that all fire doors in the centre have been inspected by a competent person to identify what actions are required to ensure the fire doors are capable of containing the fire and smoke as required.
- There were recessed light fitting within fire rated ceilings; assurance is required that the fire rating of the ceiling is maintained where penetrated by recessed light fittings.
- The entrance area had a timber sheeted ceiling. Assurance is required that the timber lining to the ceiling has been appropriately treated to prevent the surface spread of fire.

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	Not compliant
Regulation 28: Fire precautions	Not compliant

Compliance Plan for Ashley Lodge Nursing Home OSV-0000009

Inspection ID: MON-0044450

Date of inspection: 01/08/2024

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: All actions from the fire risk assessment have been addressed. A new fire safety risk assessment will be completed by June 30th 2025 All fire doors have been audited, and a plan for repair or replacement is in place. This work, dependent on manufacturing lead times, is expected to be completed by 31/01/2025. A six-monthly audit of all fire doors will continue thereafter by the maintenance team. A complete audit of all fittings that penetrate the ceiling will be conducted to ensure compliance with fire regulations. The audit will be completed by 30/11/2024, and any identified issues will be addressed by 31/12/2024. The timber-sheeted ceiling in the entrance hall will be painted with fire-retardant paint by 31/12/2024. The provider has discussed and agreed with the current engineer increasing the type of monitoring of the structure of the facility (this will include supportive data) and will commence quarterly from 1 January 2025. The provider is undertaking work to add a shower room with toilet facilities in Corridor 2. In addition, a hair salon will be installed in the same corridor. An application to vary will be submitted, and the work is expected to be completed by 31/03/2025. A new storeroom has been identified for securing Schedule 3 documents. An application to vary will be submitted to HIQA, and this action will be completed by 30/12/2024.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises:	

The provider is undertaking work to add a shower room with toilet facilities in Corridor 2. In addition, a hair salon will be installed in the same corridor. An application to vary will be submitted, and the work is expected to be completed by 31/03/2025.
The provider has discussed and agreed with the current engineer increasing the type of monitoring of the structure of the facility (this will include supportive data) and will commence quarterly from 1 January 2025.
By 30/11/2024, the flooring in two bedrooms, as identified during the inspection, will be replaced. A regular audit by housekeeping and the Person in Charge will identify any additional flooring upgrades required, in a timely manner.
By 31/10/2024, the bathroom fan will be replaced, and additional work will be carried out to improve odour control in the bathroom.
A ramp providing access to the secure garden will be upgraded by 31/10/2024
A new storeroom has been identified for securing Schedule 3 documents. An application to vary will be submitted to HIQA, and this action will be completed by 30/12/2024.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A new storeroom has been identified for securing Schedule 3 documents. An application to vary will be submitted to HIQA, and this action will be completed by 31/01/2025.
By the 31/10/2024, a mag lock connected to the fire alarm will be installed on the entrance door at reception, ensuring timely access to the fire panel.
By the 31/10/2024, all signage on fire doors will be reviewed and updated.
The gravel tracks in the pathways outside the building are under review to improve accessibility- this review with options will be completed by 31st December 2024.
The thresholds will be reviewed to ensure independent access, with any necessary adjustments completed following the review. This will be completed by 30/11/2024
By 30/11/2024, a review of all exit signs will be conducted to ensure visibility from all areas.
We have reviewed kitchen compartmentation. We can confirm ceiling is of greater than 18mm thickness, meeting fire compartmentation guidelines. We are increasing the corridor door's fire rating to 60min from 30min which was required on the fire certificate. This is to create additional safe area in the event of an emergency. This work will be completed by 31/01/2025.
Assurances regarding emergency lighting have been emailed to HIQA following the report. The annual inspection for and testing for emergency lighting for 2024 was completed as scheduled on 02/08/2024 and all works identified during this inspection have been completed. The inspection report is attached to this compliance plan for the inspector's assurance- complete
Fire detection systems have been installed in all areas identified during the inspection. An audit of all rooms has also been completed to ensure that a fire detection system is present in every area- complete
All fire doors have been audited, and a plan for repair or replacement is in place. This work, dependent on manufacturing lead times, is expected to be completed by

31/01/2025. A six-monthly audit of all fire doors will continue thereafter by the maintenance team.
A complete audit of all fittings that penetrate the ceiling will be conducted to ensure compliance with fire regulations. The audit will be completed by 30/11/2024, and any identified issues will be addressed by 31/12/2024.
The timber-sheeted ceiling in the entrance hall will be painted with fire-retardant paint by 31/12/2024.

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(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 the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	31/03/2025
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	31/03/2025
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure	Not Compliant	Orange	30/06/2025

	that the service provided is safe, appropriate, consistent and effectively monitored.			
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.	Substantially Compliant	Yellow	31/01/2025
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/01/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/01/2025