**Health Information and Quality Authority**  
**Social Services Inspectorate**

**Inspection report**  
**Designated centres for older people**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Ashborough Lodge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>0194</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Lyre Road</td>
</tr>
<tr>
<td></td>
<td>Milltown</td>
</tr>
<tr>
<td></td>
<td>Co Kerry</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>066-9765100</td>
</tr>
<tr>
<td>Fax number:</td>
<td>066-9765070</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:nursemanager@allenfield.ie">nursemanager@allenfield.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>[ ] Private</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Allenfield Care Homes Ltd</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Sheilah Climaco</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>14 April 2011</td>
</tr>
<tr>
<td>Time inspection took place:</td>
<td>Start: 09:00hrs  Completion: 15:30hrs</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Vincent Kearns</td>
</tr>
<tr>
<td>Support inspector:</td>
<td>N/A</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>[ ] Application to vary registration conditions</td>
</tr>
</tbody>
</table>
About inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are compliance with the requirements and conditions of their registration and meet the Standards, that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Additional inspections take place under the following circumstances:

- To follow up on specific matters arising from a previous inspection to ensure that the action required of the provider has been taken
- Following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Social Services Inspectorate that a provider has appointed a new person in charge
- Arising from a number of events including information received in relation to a concern/complaint or notification to the SSI of a significant event affecting the safety or well-being of residents
- To randomly “spot check” the service.

All inspections can be announced or unannounced, depending on the reason for the inspection and may take place at any time of day or night.

All inspection reports produced by the Health Information and Quality Authority will be published. However, in cases where legal or enforcement activity may arise from the findings of an inspection, the publication of a report will be delayed until that activity is resolved. The reason for this is that the publication of a report may prejudice any proceedings by putting evidence into the public domain.

The report is available to residents, relatives, providers of services and members of the public, and is published on our website www.hiqa.ie.
About the centre

**Description of services and premises**

Ashborough Lodge was purpose-built in 2003 to accommodate 58 older people on a long-term basis. The building incorporates a 13-bed dementia unit as well as an area dedicated to people needing respite and convalescent care. There are two other wings that are dedicated to the long-term care of older people.

On entering the building there is a reception area and a meeting room. To the right is a large day centre where all activities for residents take place. Residents’ accommodation can be accessed through double doors to the left of the reception. There is a lobby where visitors are required to sign in. There is also a notice board which contains the photos, names and designation of staff and a list of residents and the area they are living in, as well as their bedroom number.

The centre was designed in such a way as to promote independent living. There are three combined dining and seating areas and each has its own kitchen so that residents can get a drink or bake. All 56 bedrooms are spacious, have their own toilet and shower en suite, and a kitchenette and washer/dryer. With the exception of two twin-bedded rooms, all other rooms are for single occupancy.

All residents including those with dementia can access secured gardens. Residents not suffering from dementia have access to additional outdoor areas. These areas are all furnished with outdoor seating.

There is a large car park at the front entrance for staff and visitors.

**Location**

The centre is within walking distance of Milltown village, in Co Kerry. Milltown is 7 km from Killorglin and 13 km from Killarney.

| Date centre was first established: | 20 March 2003 |
| Number of residents on the date of inspection: | 57 |
| Number of vacancies on the date of inspection: | 0 |

| Dependency level of current residents | Max | High | Medium | Low |
| Number of residents | 18 | 13 | 18 | 8 |
Management structure

The Registered Provider, Allenfield Care Homes Ltd, is represented by one of its four directors, Bernt Krabberd. However, as Mr Krabberd resides abroad, the Person in Charge, Sheilah Climaco, acts on his behalf in this country and has authority to make managerial decisions. She is supported in this role by a consultant/accountant who retains oversight of this and another centre owned by the same provider. There is a Senior Staff Nurse who deputises in the absence of the Person in Charge. From 17:00hrs every day, there is a nurse allocated to take charge of the centre. Each ward has a team of staff allocated to it. The Person in Charge allocates a staff nurse, a team leader (senior care assistant) and the necessary number of care staff to each area. All staff report directly to the Person in Charge.

<table>
<thead>
<tr>
<th>Staff designation</th>
<th>Person in Charge</th>
<th>Nurses</th>
<th>Care staff</th>
<th>Catering staff</th>
<th>Cleaning and laundry staff</th>
<th>Admin staff</th>
<th>Other staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of staff on duty on day of inspection</td>
<td>1</td>
<td>4</td>
<td>11</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Background

The previous inspection was an announced registration inspection conducted over two days on 17 May 2010 and 18 May 2010.

Overall, inspectors concluded that this centre provided high quality care to its residents. The management and staff were committed to the residents and there were good working relationships between staff and management.

The main significant measures identified from this previous inspection were in relation to the governance of the centre: that the provider had not established a quality system for reviewing and improving the quality and safety of care provided to residents. Other significant improvements were required in relation to restraint practices, medication management and staff training.

There were some improvements needed in relation to the statement of purpose, inadequate risk management procedures, arrangements for managing complaints, and meeting the legal requirements. There were some improvements identified in relation to the centre’s premises and the benefits of assistive equipment.

Inspectors identified a need for improvement in respect of the dementia service and, in general, opportunities for residents to engage in meaningful activities and care planning.
Summary of findings from the follow up inspection

This inspection was the centre’s second inspection undertaken by the Health Information and Quality Authority. This inspection was part of the registration process; the registered provider had to satisfy the Chief Inspector of the Social Services Inspectorate that she was fit to provide the service and that the service will comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

The inspector met with residents and staff, reviewed and examined relevant documents such as staff rosters, statement of purpose, personnel files, safety statement, policies and resident care plans. The inspector viewed the alterations and improvements that had been made as a result of the requirements of the previous inspection report’s action plan. The inspector spent time with residents and observing practice to gain a greater insight into residents’ experience of the service.

Overall, the inspector concluded that this centre provides high quality care. The inspector spoke to the senior nurses in charge who demonstrated that they were committed to the welfare and wellbeing of the residents. They also demonstrated that they are endeavouring to provide effective leadership for staff.

The inspector found evidence that the provider has implemented a number of the actions as required under the registration inspection; however there were some improvements required that have not been implemented.

There were improvements required regarding the centre’s fire safety, health and safety practices in relation to fire doors, and the safe storage of cleaning materials. There were improvements required in relation to the following:

- inadequate documentation surrounding the use of lap belts and bed rails
- insufficient levels of staff in attendance at the centre’s fire safety, dementia-specific care and elder abuse training
- complaints policy was incomplete
- the centre had not returned any quarterly incidents returns to the Authority
- inadequate risk management policy and procedures available regarding residents smoking in the centre.
- the personnel files reviewed by inspectors did not contain evidence of compliance with the requirements of Schedule 2.
Issues covered on inspection

1. **Action required from previous inspection:**

Clarify the name of the person responsible on behalf of the company for the application and his or her relationship with the company.

This issue has been clarified with the Authority. The person in charge (PIC) is also the named provider. In addition there has been a recent appointment of a senior staff nurse which ensures that there are now two senior staff nurses available to support the PIC.

2. **Action required from previous inspection:**

Make a report in respect of any review and make a copy of the report available to residents and, if requested, to the Chief Inspector.

Provide for consultation with residents and their representatives when establishing and maintaining a quality system.

There are residents’ committee meetings held every quarter in which all residents are encouraged/facilitated to participate. The inspector viewed minutes of such meetings and was shown a copy of the recently introduced ‘social care needs plan form’. The inspector viewed evidence of active residents’ involvement and consultation signed in reviewed care plans.

All issues discussed at the residents’ committee meetings are disseminated to all residents via the centres newsletter. In advance to such meetings all residents are provided with a resident’s questionnaire to ascertain their opinions and assist in forming the agenda for these meetings. The inspector viewed evidence of such residents’ contributions/suggestions being actively acted upon. Residents’ relatives were also consulted as appropriate to meet the needs of residents.

3. **Action required from previous inspection:**

Document the assessment of each resident prior to the initiation of physical restraint. The assessment must identify and consider:

- the specific medical symptom to be treated by the use of physical restraint
- the steps taken to identify the underlying physical and/or psychological causes of the medical symptom
- the alternative measures that have been taken, for how long, how recently
and with what results

the evidence that a physical restraint will benefit the symptom

the risks involved in using the physical restraint

the specific circumstances under which physical restraint is being considered

the type of physical restraint, period of physical restraint and location of physical restraint.

Ensure that the resident is not restrained without his/her informed consent.

The inspector viewed a number of residents’ care plans that demonstrated that most of these required actions have been implemented in the centre in relation to the use or the contemplation of the use of restraint. However, a number of the residents’ restraint forms viewed were incomplete, with no evidence of ongoing monitoring or review of the use of restraint available to the inspector. In addition, the restraint policy was not signed by the PIC and there was no review date provided for in relation to the restraint policy.

There was evidence of the residents’ consent being provided in relation to the use of restraint. However, a number of the centre-specific restraint consent forms viewed were not signed by the residents’ GPs.

4. Action required from previous inspection:

Clearly document that residents’ medications are reviewed three monthly or more frequently if required.

Establish an overall policy for the management of medication, including review/monitoring of medications and reporting errors.

Establish written policies and procedures for:

- prescribing

- prn (as necessary) prescribing and administration.

Establish a system and written procedures for the ongoing audit of medication management.

The inspector viewed evidence of residents’ medications being reviewed regularly and there is a centre specific medication policy that includes the effective reporting of errors, prescribing and the management of prn medication administration.
relation to ongoing audit of medication management there was a centre-specific system, including written procedures, which was made available to the inspector.

5. **Action required from previous inspection:**

Ensure that staff members have access to education and training to enable them to provide care to residents with dementia in accordance with contemporary evidence-based practice.

Ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made thereunder, commensurate with their role, the statement of purpose and with any policies and procedures dealing with the general welfare and protection of residents.

The inspector was informed that all staff are provided with information regarding the provisions of the Act and all regulations and rules made thereunder, commensurate with their role. There were copies of relevant documents available in the centre.

On 15 March 2011 and 16 March 2011 the centre facilitated the attendance of five staff nurses and eleven healthcare assistants on a two-day training workshop in dementia/challenging behaviour.

6. **Action required from previous inspection:**

Revise the policy so that it includes procedures for preventing abuse and reporting to the Garda Síochána and the Chief Inspector. It should clearly explain to staff how the “November 2007 Ratified Elder Abuse Policy” is to be referred to.

The inspector viewed a policy on elderly abuse and the procedures for reporting such to the Garda Síochána and the Chief Inspector. In addition, one staff nurse and one healthcare assistant attended an elder abuse training course provided in St Luke’s Home in March 2011. Staff in the centre have been provided with the opportunity to view the HSE DVD on “Recognising and Responding to Elder Abuse in Residential Care Settings”. However, there was no record of staff attendance at such viewing available on the day of inspection.

7. **Action required from previous inspection:**

Revise the statement of purpose so that it clearly outlines the aims, objectives and ethos of the centre. It should also be revised so that it accurately details:

- name and address of the registered provider and the person in charge
- current professional registration, relevant qualifications and experience of the
provider and any person in charge

name and position of each other person participating in the management

total staffing complement in whole time equivalents for the centre, with the management and nursing complements given by grade

organisational structure of the centre

gender of the residents for whom it is intended that accommodation should be provided

type of nursing care to be provided

any criteria used for admission to the designated centre, including the policy and procedures for emergency admissions

the arrangements made for consultation with residents about the operation of the designated centre

arrangements for contact between residents and their relatives, friends and/or carers

the arrangements made for dealing with reviews of the resident’s plan referred to in article 8(1)

size of rooms in the centre

arrangements made for the supervision of therapeutic techniques

arrangements made for respecting the privacy and dignity of residents.

The inspector was provided with a copy of the statement of purpose which was satisfactory.

8. **Action required from previous inspection:**

Put in place arrangements for the investigation and learning from serious or untoward incidents or adverse events involving residents.

Develop a comprehensive written risk management policy and ensure that it is implemented throughout the designated centre.

The inspector viewed a copy of a written risk management policy that was centre specific and comprehensive. However, it was unclear what effective arrangements are in place for the learning from serious or untoward incidents or adverse events
involving residents. There was no provision for risk assessing smoking in the centre. The risk management policy was not signed by the PIC and there was no review date evident.

9. **Action required from previous inspection:**

Ensure, by means of fire drills and practices at suitable intervals, that the persons working at the designated centre and, insofar as is reasonably practicable, residents are aware of the procedure to be followed in the case of fire, including the procedure for saving life.

Provide to the Chief Inspector, together with the application for registration or renewal of registration, written confirmation from a competent person that all the requirements of the statutory fire authority have been complied with.

The inspector viewed fire records and evidence of staff training in fire drills and evacuation provided on 1 March 2011; however, there was an insufficient number of staff attending this training.

All fire doors are checked weekly by a nominated person and the fire panels are checked by the nurse in charge each day; however there was no record available of these checks on the day of inspection. The inspector observed that a number of designated fire doors in a number of different areas were wedged open. The senior staff nurse was informed of this and requested to remove all ‘door wedges’. Following this inspection the senior staff nurse provided the inspector with written confirmation in relation to the door wedges stating that all had been removed from the fire doors and staff have been made aware of the importance of not wedging fire doors in the centre.

The provider has made available satisfactory written confirmation from a competent person stating that all the requirements of the statutory fire authority have been complied with.

10. **Action required from previous inspection:**

Revise the policy and procedures so that it details the internal arrangements for handling complaints.

Display the complaints procedure in a prominent place within the centre.

The policy and procedures of the centre were viewed by the inspector and have been satisfactorily amended to include details of the internal arrangements for handling complaints. However, the policy viewed was not signed, there was no capacity for the review of this policy’s implementation or any facility to measure the
resident/complainant’s level of satisfaction or otherwise with the outcome of their complaint.

The inspector observed that the complaints procedure is displayed prominently in the main entrance of the centre.

11. **Action required from previous inspection:**

Ensure each resident’s needs are set out in an individual care plan developed and agreed with the resident, including their health, personal and social care needs.

Keep the residents’ care plan under formal review as required by the residents’ changing needs or circumstances and no less frequently than at three-monthly intervals, and notify the residents of any review.

A number of residents' care plans were reviewed by the inspector and there was evidence that each resident's needs were individually set out within their care plan with each resident agreeing with the nurse as appropriate a number of aspects of their health, personal and social care needs.

There was evidence of care plans being allocated to individual nursing staff with formal review of residents’ care plans at a minimum of three-monthly intervals or more often if required.

Residents are also notified of such reviews and facilitated in participating in reviews as appropriate. However, there were two residents who smoked in the centre and this need was did not adequately reflected in their care plans.

12. **Action required from previous inspection:**

Make arrangements to facilitate and encourage residents with dementia to communicate, including the provision of techniques such as life stories, reminiscence, reality orientation, validation, sensory equipment and music.

The inspector viewed new signage that was colourful, imaginative and individually tailored to assist residents with dementia to navigate their way around the unit. There is a newsletter for the centre that is published following each residents’ committee meeting and copies are made available to all residents, also each edition of the newsletter is read out to the residents in the dementia unit. There is a pampering day each Wednesday and live music sessions provided in the day care centre. Rummage boxes are provided, photo albums for individual resident’s use and newspapers and radio are made available to residents.
There are new sensory lights and the development of a “Bare Feet Track”, which is a multi-sensory experience, in the nearby fenced-in garden. However, this fenced area was not adequately secure to ensure the safety of the residents.

13. **Action required from previous inspection:**

Provide opportunities to participate in activities appropriate to each resident’s interests and capacities.

The inspector viewed a centre-specific social care plan aimed at assisting the centre to assess the social care needs of each resident. Residents’ committee meetings are also held regularly.

There are a variety of social options available to residents such as art classes every Thursday, fit for life each Friday, gardening: ongoing, pet therapy most days, access to day care every Thursday with live music provided.

The centre has a suggestion box for any ideas or queries and four staff are due to participate in an advocacy training course in June 2011.

14. **Action required from previous inspection:**

Make arrangements for adequate seating, recreational and dining space separate from the residents’ private accommodation.

The physical design and layout of the premises to be used as the designated centre meets the needs of each resident with dementia.

There have been a number of adjustments made to the day room in the dementia specific unit and the inspector was informed that a round dining room table had been ordered to provide more opportunities for residents to be able to dine in one sitting if they wish. However, there were limited designated areas with adequate seating, recreational and dining space separate from the residents’ private accommodation.

15. **Action required from previous inspection:**

Provide sufficient numbers of suitable equipment to meet the needs of residents, including hoists.
The inspector was informed that a new standing hoist had been purchased and there are now three standing hoists, one in each unit, and two full hoists available in the centre.

16. **Action required from previous inspection:**

With respect to staff working in the centre, obtain the information and documents as specified in Schedule 2.

The inspector viewed a random sample of the staff personnel files and none viewed were in compliance with the requirements of Schedule 2.
Closing the visit

At the close of the inspection visit a feedback meeting was held with the senior staff nurses to report on the inspector’s findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, provider and staff during the inspection.

REPORT COMPILED BY

Vincent Kearns  
Inspector of Social Services  
Social Services Inspectorate  
Health Information and Quality Authority

14 April 2011

<table>
<thead>
<tr>
<th>Chronology of previous HIQA inspections</th>
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<tr>
<td><strong>Date of previous inspection:</strong></td>
</tr>
<tr>
<td>17 May 2010 and 18 May 2010</td>
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Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Ashborough Lodge</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>0194</td>
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<td>Date of inspection:</td>
<td>14 April 2011</td>
</tr>
<tr>
<td>Date of response:</td>
<td>23 May 2011</td>
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Requirements

These requirements set out what the registered provider must do to meet the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended), the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

1. The provider is failing to comply with a regulatory requirement in the following respect:

There was inadequate securing of storage facilities for the centre’s disinfectant and cleaning materials, including hazardous liquids.

Action required:

Take all reasonable measures to prevent accidents to any person in the designated centre.

Action required:

The physical design and layout of the premises to be used as the designated centre did not meet the needs of each resident with dementia in that there was inadequate securing of storage facilities for the centre’s disinfectant and cleaning materials including hazardous liquids.
### Please state the actions you have taken or are planning to take with timescales:

<table>
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<tr>
<th>Provider's response:</th>
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<tr>
<td>Completed</td>
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### 2. The provider is failing to comply with a regulatory requirement in the following respect:

There were inappropriate practices and inadequate/incomplete documentation surrounding the use of lap belts and bed rails.

### Action required:

Document the assessment of each resident prior to the initiation of physical restraint. The assessment must identify and consider:

- the specific medical symptom to be treated by the use of physical restraint
- the steps taken to identify the underlying physical and/or psychological causes of the medical symptom
- the alternative measures that have been taken, for how long, how recently and with what results
- the evidence that a physical restraint will benefit the symptom
- the risks involved in using the physical restraint
- the specific circumstances under which physical restraint is being considered
- the monitoring/review of each episode of restraint.

### Reference:

Health Act 2007  
Regulation 25: Medical Records  
Standard 21: Responding to Behaviour that is Challenging

<table>
<thead>
<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
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<tr>
<td>Completed</td>
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</table>

Provider’s response:

Physical restraint policy has been reviewed and updated. Physical restraint observation form is in place for all residents with bed rails,
lap belts, etc. All staff were advised not to leave any blanks on the assessment and consent form for physical restraint. A policy is in place for doctors to sign the physical restraint form in all cases.

3. The provider has failed to comply with a regulatory requirement in the following respect:

There was inadequate training provided to staff regarding:
- dementia-specific care

**Action required:**

Ensure that all staff members have access to education and training to enable them to provide care to residents with dementia in accordance with contemporary evidence-based practice.

**Reference:**
- Health Act 2007
- Regulation 17: Training and Staff Development
- Standard 24: Training and Supervision

**Please state the actions you have taken or are planning to take with timescales:**

<table>
<thead>
<tr>
<th>Provider’s response:</th>
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</thead>
<tbody>
<tr>
<td>We will organise further trainings for the remaining staff.</td>
</tr>
<tr>
<td>We had training on dementia and challenging behaviour in March for 16 out of 51 care staff. Trained staff are sharing their knowledge with their colleagues and any issues are addressed in regular staff meetings.</td>
</tr>
<tr>
<td>Four staff members will go on advocacy training on 30 June 2011.</td>
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<table>
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<tr>
<th>Timescale:</th>
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</thead>
<tbody>
<tr>
<td>23 November 2011</td>
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</table>

4. The provider has failed to comply with a regulatory requirement in the following respect:

The implementation of the policy on the prevention, detection and response to abuse was inadequate.

**Action required:**

Make all necessary arrangements, by providing adequate training of staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.
### Action required:

Maintain appropriate records of all staff training to ensure effective management and ongoing monitoring is provided.

### Action required:

Put in place arrangements for the investigation and learning from serious or untoward incidents or adverse events involving residents.

### Reference:

Health Act 2007  
Regulation 16: Staffing  
Regulation 6: General Welfare and Protection  
Standard 23: Staffing Levels and Qualifications

### Please state the actions you have taken or are planning to take with timescales:

<table>
<thead>
<tr>
<th>Provider’s response:</th>
<th>Timescale:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashborough Lodge elder abuse policy was reviewed and updated. Two DVDs were provided to all the staff to watch and to confirm through their signature after watching same and reading the elder abuse policy of Ashborough Lodge. DVD 1: Recognising and responding to elder abuse in residential care settings (HSE); DVD 2: Open your eyes to elder abuse in your community (HSE).</td>
<td>Completed</td>
</tr>
</tbody>
</table>

### 5. The provider is failing to comply with a regulatory requirement in the following respect:

There were inadequate policies and procedures in place for effective risk management.

### Action required:

Ensure risk management policy is evidenced to best practice, signed and dated by the author, and reviewed at a minimum of every three years.

### Reference:

Health Act 2007  
Regulation 31: Risk Management Procedures  
Standard 26: Health and Safety
Please state the actions you have taken or are planning to take with timescales:

<table>
<thead>
<tr>
<th>Provider’s response:</th>
<th>Timescale:</th>
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<tbody>
<tr>
<td>Ashborough Lodge risk management policy was reviewed and updated and staff are all required to read and confirm through their signature.</td>
<td>Completed</td>
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</table>

### 6. The provider is failing to comply with a regulatory requirement in the following respect:

A number of designated fire doors in a number of different areas within the centre were wedged open.

There were inadequate numbers of staff attending fire safety training and evacuation procedures.

The documentation received with the centre’s application for registration did not adequately confirm that the centre complied with all the requirements of the statutory fire authority.

**Action required:**

Remove all door wedges and make adequate arrangements for detecting, containing and extinguishing fires including adherence with fire regulations in relation to the management of designated fire doors.

**Action required:**

Ensure, by means of fire drills and practices at suitable intervals, that all persons working at the designated centre and, insofar as is reasonably practicable, residents are aware of the procedure to be followed in the case of fire, including the procedure for saving life.

**Action required:**

Provide to the Chief Inspector, together with the application for registration or renewal of registration, written confirmation from a competent person that all the requirements of the statutory fire authority have been complied with.

**Reference:**

Health Act 2007  
Regulation 32: Fire Precautions and Records  
Standard 26: Health and Safety
**Please state the actions you have taken or are planning to take with timescales:**

<table>
<thead>
<tr>
<th>Action</th>
<th>Timescale</th>
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<tbody>
<tr>
<td><strong>Provider’s response:</strong></td>
<td></td>
</tr>
<tr>
<td>All the bedroom doors and sitting room doors are equipped with magnets responding to fire alarms. The form regarding compliance with statutory requirements relating to Fire Safety and Building Control was completed on 22 April 2011 and sent back to HIQA. In house fire drill training is ongoing. Fire drill training will be arranged for the remaining staff.</td>
<td>Completed</td>
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<tr>
<td></td>
<td>23 August 2011</td>
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</tbody>
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**7. The provider is failing to comply with a regulatory requirement in the following respect:**

The complaints policy and procedures were not fully compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

**Action required:**

Inform complainants promptly of the outcome of their complaints and details of the appeals process.

**Action required:**

Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.

**Action required:**

Revise the policy and procedures so that it details that the internal arrangements for handling complaints is evidenced to best practice, signed and dated by the author, and reviewed at a minimum of every three years.

**Reference:**

- Health Act 2007
- Regulation 39: Complaints Procedures
- Standard 6: Complaints

**Please state the actions you have taken or are planning to take with timescales:**

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<thead>
<tr>
<th>Action</th>
<th>Timescale</th>
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</thead>
<tbody>
<tr>
<td><strong>Provider’s response:</strong></td>
<td></td>
</tr>
<tr>
<td>Ashborough Lodge complaints policy was reviewed and updated and</td>
<td>Completed</td>
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</table>
all staff are required to read same and confirm through their signatures. Forms for verbal or written complaints are in place, as well as forms for investigation and conclusion of same. A separate form is in place for employees' complaints.

8. The provider is failing to comply with a regulatory requirement in the following respect:

The care plans of two residents who smoked did not accurately reflect their subsequent appropriate care needs.

**Action required:**

Put in place suitable and sufficient care to maintain each resident's welfare and wellbeing, having regard to the nature and extent of each resident's dependency and needs.

**Reference:**

Health Act 2007
Regulation 6: General Welfare and Protection
Standard 13: Healthcare

**Please state the actions you have taken or are planning to take with timescales:**

Provider's response:

A policy for smoking is now in place in Ashborough Lodge. All smoking residents are assessed and supervised if required. Same is now recorded in the care plan.

Timescale: Completed

9. The provider is failing to comply with a regulatory requirement in the following respect:

The physical environment of the dementia unit lacked designated areas with adequate seating, recreational and dining space separate from the residents' private accommodation.

The fencing provided to secure the garden area for residents in the dementia-specific unit was inadequate to meet their safety needs.

**Action required:**

Make arrangements for adequate seating, recreational and dining space separate from the residents’ private accommodation.
### Action required:

Provide adequate fencing to ensure the safety of the residents in the dementia-specific unit.

### Action required:

Ensure that the garden area for residents in the dementia-specific unit is appropriately secured.

### Action required:

The physical design and layout of the premises to be used as the designated centre meets the needs of each resident with dementia.

### Reference:

- Health Act 2007
- Regulation 19: Premises
- Standard 25: Physical Environment

### Please state the actions you have taken or are planning to take with timescales:

<table>
<thead>
<tr>
<th>Provider’s response:</th>
<th>Timescale:</th>
</tr>
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<tbody>
<tr>
<td>Adequate seating is provided in the dementia unit. There are 12 residents in the unit at present. One of the residents spends all day in another section of the nursing home. One resident spends his day in his own room with a family member. One resident is resting in a special chair due to her medical condition. One of the residents is fed through a PEG tube. Two dining tables are available for the eight remaining residents, each of them catering for four residents. There are 10 seats available on sofas and upholstered chair in the dayroom and two double-seater benches in the corridors. Our residents always have the choice to go into their own rooms or to eat at times convenient to them, that due to our experience the seating provided is adequate at present. This arrangement is subject to change should the need arise (change of residents, change of residents’ needs, etc.)</td>
<td>Completed</td>
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</table>

| Fencing in the dementia unit garden will be elevated for the safety of the residents. The fence in the dementia unit garden currently measures 1.2m high and will be elevated with an additional picket fence to 1.40m in height and will be painted in the same colour as the existing fence. | 8 June 2011 |
10. The provider is failing to comply with a regulatory requirement in the following respect:

The recruitment policy did not include the information to be obtained with respect to Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

**Action required:**

Revise the recruitment policy so that processes for recruiting staff include the need for obtaining information and documents as specified in Schedule 2.

**Action required:**

With respect to staff working in the centre, obtain the information and documents as specified in Schedule 2.

**Reference:**

Health Act 2007  
Regulation 18: Recruitment  
Standard 22: Recruitment

<table>
<thead>
<tr>
<th>Please state the actions you have taken or are planning to take with timescales:</th>
<th>Timescale:</th>
</tr>
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</table>
| Provider’s response:  
All staff files are reviewed and all missing documents are submitted or will be submitted in two weeks time. | 8 June 2011 |
Any comments the provider may wish to make:

Provider’s response:

We at Ashborough Lodge would like to thank Mr Vincent Kearns for his professional and courteous manners he showed us throughout our inspection.

Provider’s name: Sheilah Climaco (Allenfield Care Homes Ltd.)

Date: 23 May 2011