



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:	Ashbury Nursing Home Ltd.
Address of centre:	1A Kill Lane, Kill O'The Grange, Blackrock, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	18 March 2026
Centre ID:	OSV-0000007
Fieldwork ID:	MON-0050037

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 91 bed spaces. 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:	78
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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
Wednesday 18 March 2026	14:20hrs to 20:10hrs	Aisling Coffey	Lead
Thursday 19 March 2026	07:15hrs to 15:05hrs	Aisling Coffey	Lead
Thursday 19 March 2026	07:15hrs to 15:05hrs	Yvonne O'Loughlin	Support

What residents told us and what inspectors observed

Overall, residents reported being happy living in Ashbury Nursing Home; however, some residents told inspectors that factors such as food and call bell response times negatively impacted their day-to-day experience in the centre.

This unannounced inspection was conducted over two days. One inspector of social services attended on the first inspection day, while two inspectors attended on the second inspection day, one of whom focused on the provider's compliance with infection prevention and control (IPC) oversight, practices and processes. Over the two inspection days, the inspectors spoke with 21 residents and 10 visitors to gain insight into residents' lived experiences at Ashbury Nursing Home. The inspectors also spent time observing interactions between staff and residents and reviewing a range of documentation.

Residents were highly complimentary of the staff who cared for them, telling the inspectors, "I couldn't praise them enough", "they help us in any way they can", and "they're lovely." While acknowledging the positive attributes of most staff members, one resident informed the inspector of concerns regarding the conduct of some staff members. These matters were referred to the person in charge, who engaged with the resident concerned following the inspection and subsequently submitted a safeguarding notification to the Office of the Chief Inspector, which provided assurance that the concerns raised were managed appropriately.

The inspectors found that staff and management were knowledgeable about residents' needs, and that they promoted and respected residents' rights and choices. The inspectors observed numerous friendly, compassionate, warm, dignified, and respectful interactions between residents and staff throughout the day of the inspection.

Ashbury Nursing Home is situated in South County Dublin, on the border of Blackrock and Dun Laoghaire. The premises comprise a three-storey period house, the Main House, which can accommodate 45 residents, and a modern, purpose-built two-storey extension, the Grange Wing, which can accommodate 46 residents. The Main House and the Grange Wing are connected by a link corridor on the ground floor. Travel between the floors was facilitated by three passenger lifts and chair lifts located on some stair sets.

Residents' bedroom accommodation comprised 36 single bedrooms, three twin bedrooms and two three-bedded rooms with en-suite toilet and shower facilities. There were also 11 single, 13 twin and two three-bedded rooms without en-suite facilities. Residents of these bedrooms had access to communal toilet and shower facilities. While the centre did not have a bath at the time of the inspection, the provider was planning to install one on the ground floor of the Main House, in

addition to other refurbishment works underway to increase the number of fully accessible bathroom and shower facilities in the centre.

All bedrooms seen by the inspectors were personalised with family photographs and items from home, such as paintings, bedding and ornaments. All the bedrooms had a television, a wardrobe, drawers, locked storage facilities, a land line phone, and a call bell. The provider outlined that they were progressing a schedule of premises improvement works throughout the centre for the benefit of residents, and inspectors noted that some bedrooms had been recently painted, and had new flooring and furniture. Residents whom the inspectors spoke with were pleased with their personal space and storage. The privacy and dignity of all residents in their bedrooms were respected. Suitable curtains to support privacy were observed on bedroom windows facing into gardens, the car park, and the surrounding residential areas.

The design and layout of the centre supported residents' movement throughout, with wide corridors, sufficient handrails, and comfortable seating in the various communal areas. These communal areas included two day spaces, three dining areas, two lounges and a sitting room. Communal areas were comfortable and inviting, with domestic features such as bookshelves, ornaments, and dressers, providing a homely environment for residents.

The inspectors noted that one of the ground-floor day spaces was not accessible to residents over the two inspection days, as repair work was underway following a roof leak above the link corridor. Other parts of the premises were also seen to require repair. While the centre was pleasantly decorated in many areas, with paintings and photographs of residents and staff enjoying group activities displayed, as well as some pleasant decorative features in the Main House, including chandeliers and stained-glass windows, other parts of the centre showed signs of decorative wear and tear. These matters are discussed further under Regulation 17: Premises.

While the centre was clean overall, action was required regarding infection prevention and control (IPC). For example, the sluice room facilities for cleaning and disposing of bedpans and urinals after residents' use were not laid out or maintained to prevent the spread of infection. In the Main House, there was no dedicated clean utility for storing clean supplies and medication. Inspectors observed that a small recess, which had been a previous entrance to the Main House, was used for storage, with the medication fridge located on the floor. These infection control matters are discussed further in the report under Regulation 27: Infection control.

Regarding fire safety, the provider had a designated smoking and vaping area on the ground floor. This area was seen to have the necessary protective equipment for residents who chose to smoke or vape. However, inspectors observed inappropriate storage throughout the centre, which posed a risk to resident safety in a fire emergency. Seating, hoists, chair scales, wheelchairs, medication and catering trolleys were observed to be stored in escape corridors and stairwells throughout

the premises. This and further fire safety findings are discussed under Regulation 28: Fire precautions.

The provider had building contractors on-site over the two inspection days. These contractors were engaged in planned works to convert a ground-floor sitting room and office area into a bedroom, bathroom, and office facilities, as well as attending to unplanned works following a leak that impacted four bedrooms on the first and second floors of the Main House. The Office of the Chief Inspector was notified of the planned works, and residents in the bedrooms affected by the leak had been provided with alternative bedroom accommodation. Inspectors noted that the areas where building and repair works were taking place were secured and inaccessible from inside the centre, and that the surrounding corridor areas were clean and tidy.

In terms of outdoor space, the centre had two secure gardens, which were clean, tidy, and pleasantly landscaped. The gardens had comfortable seating, garden decorations, water features, raised flower beds, and plants.

On the first inspection day, the inspector observed residents participating in chair yoga in the first-floor lounge in the early afternoon, followed by refreshments served from 3:30-4:00pm, before the tea time meal at 5:30pm. Later in the evening, some residents relaxed watching television in their bedrooms and communal areas. Other residents read, listened to the radio or hosted a visitor. There were refreshments served at 7:30pm. On the second inspection day, residents watched mass services on television in the morning, followed by an exercise class before lunch. In the afternoon, Roman Catholic Mass was celebrated in the centre.

The inspectors observed two sittings of residents' mealtimes over the two inspection days. Mealtimes were observed to be sociable and relaxed, with residents chatting and staff providing discreet, respectful assistance when required. The inspectors observed that most residents ate in the dining rooms, while a small number ate in their bedrooms. For the main meal at 1:30pm, residents were offered two main courses. Drinks were readily available for residents at mealtimes and throughout the day in bedrooms and communal areas. While many residents were complimentary of the food, several expressed dissatisfaction with the quality and variety, the way it was cooked, the temperature at which it was served, and the portion sizes. Similar matters had been raised by residents in recent questionnaires and at residents' committee meetings. In the fortnight prior to this inspection, the provider had held a targeted meeting with residents to discuss food-related concerns. Inspectors reviewed the minutes of this meeting and noted that the provider had agreed to an action plan to address residents' concerns.

Visitors were observed coming and going throughout the two inspection days. Visitors spoken with were complimentary of the care received by their loved ones and of the communication with them as a family. While praising staff members, a small number of visitors informed the inspectors that they had difficulty accessing the centre during the times when there was no receptionist on duty.

The following two sections of the report present the findings of this inspection regarding the centre's governance and management arrangements and how these

arrangements impacted the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

While established governance and management systems were in place to oversee the quality of care delivered to residents, this inspection found a decline in regulatory compliance when compared with the January 2025 inspection and that sustained focus was now required to work towards improved regulatory compliance across a number of regulations, including governance and management, as outlined in this report.

This was an unannounced inspection to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 (as amended) and to review the registered provider's compliance plan arising from the previous inspection of 29 January 2025. The provider was seen to have progressed with the compliance plan following the last inspection; however, not all action had been taken in relation to several regulations as set out in this report.

The Chief Inspector had attached a restrictive condition requiring the registered provider to complete an assessment of all fire doors in the centre, increase the number of fully accessible bathroom / shower facilities and complete the refitting / refurbishment of the equipment cleaning room by 30 June 2024. The provider continued to engage with the Office of the Chief Inspector regarding this condition, however, the refurbishments had not yet been completed. The provider submitted an assessment of all fire doors in the centre, and outstanding works were ongoing at the time of the inspection, to meet the remaining requirements of the restrictive condition. This inspection informed a review of the progress of these refurbishment works.

The registered provider is Ashbury Nursing Home Limited. The company has three directors, one of whom is the managing director and represents the provider for regulatory matters. Since the last inspection in January 2025, there have been changes in the centre's governance and management, including the appointment of a new person in charge and the reappointment of the director of operations, who had been the person in charge for a four-month period in 2025.

There was a clearly defined management structure which identified lines of accountability and responsibility for the service. The person in charge was responsible for the centre's day-to-day operations and reported to the managing director, who in turn reported to the company directors. The director of operations is a person participating in management. This is a senior member of staff who

supports the person in charge in their operational management and clinical oversight of the centre.

The person in charge worked full-time and was supported in their management of the centre by an assistant director of nursing, two clinical nurse managers, a house manager, a team of staff nurses, care managers, healthcare assistants, an activities coordinator, administration, catering, household, and maintenance staff. The assistant director of nursing deputised for the person in charge. On the day of inspection, there was one clinical nurse manager vacancy that had arisen in January 2026 and for which the provider was actively recruiting. Based on discussions with residents and a review of documentation, including residents' committee meeting minutes, it was found that the current staffing levels and skill mix did not consistently meet residents' assessed needs, specifically in relation to timely call bell responses. This staffing matter is discussed further under Regulation 15: Staffing.

Staff were appropriately supervised and clear about their roles and responsibilities. The inspectors reviewed the provider's written plans for the roll out of a staff performance appraisal programme in 2026. Records reviewed found that staff had access to a suite of mandatory training in areas such as safeguarding, infection control and fire safety to support them in their role. Notwithstanding this good practice, some gaps were found in the number of staff who were up to date with the required training, as discussed under Regulation 16: Training and staff development.

There was documentary evidence of the communication systems in place between the registered provider and management within the centre. Minutes of regular governance meetings were reviewed. These meetings discussed key aspects of care provision for residents, including premises, facilities, staffing and training requirements. Within the centre, there was evidence of staff meetings focused on key quality and safety areas, including housekeeping, mealtimes, incidents, and clinical care.

The provider had a risk register to monitor and manage known risks in the centre. The provider had undertaken auditing since the previous inspection, covering areas such as restrictive practices, health and safety, medication management, call bell audits and premises. These audits identified risks in service provision, and action plans were developed to address them and improve safety. Notwithstanding these good practices identified in the centre's governance and management systems and processes, some further improvements were required to sustain quality improvement when risks were identified. These matters are discussed under Regulation 23: Governance and management.

The provider was progressing the annual review of the quality and safety of care delivered to residents for 2025, and the inspectors received a copy of this review after the inspection. There was evidence of consultation with residents and families reflected in the review. In this review, the registered provider also identified areas requiring improvement, including premises, food, visitor access to the centre and the requirement for care plan meetings to involve residents and/or their nominated representative in care plan reviews.

While the provider had a system to oversee accidents and incidents within the centre, further oversight was required to ensure all notifiable incidents are reported to the Chief Inspector of Social Services within the required time frames, as discussed under Regulation 31: Notification of incidents.

Regulation 14: Persons in charge

The person in charge met the regulatory requirements. They are an experienced registered nurse with previous management experience and post-registration management qualifications.

Judgment: Compliant

Regulation 15: Staffing

The provider had not consistently ensured that the number and skill mix of staff was appropriate, to meet the assessed needs of all residents. A small number of residents expressed concern about delays in receiving assistance with personal care after ringing their call bells. Similar concerns were also recorded in the residents' committee meeting minutes reviewed.

Judgment: Substantially compliant

Regulation 16: Training and staff development

While staff had access to a suite of training programmes to enable them to perform their respective roles, some gaps in adherence to mandatory training requirements were found; for example, 33 staff had not completed IPC training, eight staff had not completed safeguarding training, and three staff had not completed fire safety training. The provider confirmed to inspectors that training had been booked to address these needs in the weeks following the inspection.

Inspectors found that the supervision of staff practices was insufficient as evidenced by;

- A review of pressure-relieving equipment found that the residents' body weight, on a number of air alternating mattresses, had been entered incorrectly. As a result, the mattresses were unable to provide the level of support needed to promote the healing of a pressure ulcer.

Judgment: Substantially compliant

Regulation 23: Governance and management

While the provider had management systems to monitor the quality and safety of service provision, these oversight mechanisms did not effectively identify deficits and risks in service provision and continuously drive sustained quality improvement when risk was identified, for example:

- The oversight systems in place to ensure that residents received appropriate pressure ulcer care in line with their assessed needs required review. This is discussed under Regulation 16: Training and staff development.
- The audits related to infection control did not identify the deficits and risks in service provision identified by inspectors during this inspection. This is discussed further under Regulation 27: Infection control.
- Oversight systems in place to ensure the implementation of the providers policies was ineffective, for example;
 - On three occasions, neurological observation assessments were not monitored and documented in accordance with the provider's falls policy following an unwitnessed fall.
 - The turning chart for one resident was not fully completed in line with the providers' procedures.
- The management systems for incident reporting did not ensure full and accurate recording of incidents occurring in the centre. For example, the inspectors saw incidents documented as having been reported to the person in charge, but the person in charge confirmed they had not been notified. Inspectors also found gaps in incident recording, where the investigation into the incident, to determine causal and contributory factors, as well as the action plan to reduce the likelihood of recurrence, had not been documented in the provider's electronic record system.
- The oversight systems for ensuring that residents' records were securely and safely stored were insufficient, as inspectors found records relating to some aspects of residents' daily care, such as wound care and positioning charts, accessible in the reception area on the first floor of the Main House.
- The oversight systems in place to ensure the submission of required information to the Chief Inspector were not sufficiently robust. This is discussed under Regulation 31: Notification of incidents.

Judgment: Not compliant

Regulation 31: Notification of incidents

The provider did not notify the Chief Inspector of five unexplained absences and one allegation of abuse, as required by the regulations.

Judgment: Not compliant

Quality and safety

While the inspectors observed kind and compassionate staff treating residents with dignity and respect, enhanced governance and oversight were required to improve the quality and safety of service provision. Action was required to ensure regulatory compliance with individual assessment and care planning, protection, premises, food and nutrition, infection control, and fire safety, as set out in this report.

The health of residents was promoted through ongoing medical reviews and access to a range of external community and outpatient-based healthcare providers, including physiotherapists, dietitians, speech and language therapists, and palliative care services. The records reviewed showed evidence of ongoing referral and review by these healthcare services for the residents' benefit.

Systems were in place to safeguard residents and protect them from abuse. The provider confirmed that they did not act as a pension agent for any residents. Staff received training on safeguarding residents from abuse. The provider had a safeguarding policy to support and guide staff in recognising and responding to allegations of abuse. Records were reviewed, which evidenced that the person in charge had investigated incidents and allegations of abuse. Notwithstanding these good practices, inspectors found that an incident of alleged abuse had not been investigated in line with the regulations and managed in line with the centre's safeguarding policy, as discussed under Regulation 8: Protection.

As referenced in the capacity and capability section of the report, the provider was engaged in a programme of works to increase the number of fully accessible bathroom/shower facilities in the centre, and to complete the refitting/refurbishment of the equipment cleaning room. Inspectors also noted that other bedroom refurbishments, including painting and flooring replacements, had recently been carried out, improving the standard of accommodation for the residents in those rooms. The centre had two secure outdoor areas, which were pleasantly landscaped. While the centre was pleasantly decorated in many areas, creating a homely atmosphere, some areas required further maintenance and repair to fully comply with Schedule 6 requirements, as discussed under Regulation 17: Premises.

Food was freshly prepared and cooked on-site by the centre's chefs. Residents were offered a choice at mealtimes. Residents had access to fresh drinking water and other refreshments at mealtimes and throughout the day. There was adequate supervision and discrete, respectful assistance at mealtimes. While many residents were complimentary about the meals, there was evidence of ongoing concerns

raised by some residents regarding the quality of the food which is further discussed under Regulation 18: Food and nutrition.

The centre was clean on the day of the inspection. There were sufficient housekeeping staff to meet the centre's needs. The provider had several processes in place to maintain a high standard of environmental hygiene. These included cleaning instructions, checklists and colour-coded cloths to reduce the chance of cross-infection. Housekeeping trolleys were clean and well-maintained, with a lockable store for chemicals. Hand sanitisers were available in wall-mounted dispensers along the corridors and at the point-of-care for each resident. Clinical hand-wash sinks that met the recommended specifications were available in all areas of the centre where residents lived. This meant that staff could easily wash their hands if visibly soiled. An Aspergillus risk assessment was in place to protect residents from infection during ongoing building works at the centre. The person in charge had overall responsibility for infection prevention and control (IPC) and antimicrobial stewardship. The provider had also appointed the assistant director of nursing as the trained infection control link nurse to provide specialist expertise. Residents were supported to access recommended vaccines, in line with the national immunisation guidelines. Notwithstanding these good practices, inspectors found that the environment and equipment were not managed to comply with the *National Standards for Infection Prevention and Control in Community Services* (2018) and other national guidance on IPC, as discussed under Regulation 27: Infection control.

The provider had multiple systems to monitor fire safety. Preventive maintenance for fire detection, fire-fighting equipment and emergency lighting was conducted at recommended intervals. Procedures for responding to a fire were available to staff. Staff had undertaken fire safety training and participated in regular fire evacuation drills. Each resident had a personal evacuation plan to guide staff in an emergency requiring evacuation. There was a system for checking the fire alarm, fire doors, fire safety equipment and means of escape. While there was evidence of these good practices, further actions were required to maintain the means of escape and ensure clarity regarding fire compartment boundaries, to protect residents from fire risk and to enable staff to respond appropriately in the event of a fire. These findings are set out under Regulation 28: Fire precautions.

Regulation 11: Visits

The provider had a written visitor policy as required by the regulation. Visitors were observed coming and going to the centre on the days of inspection. Residents could meet with visitors in private or in the centre's communal spaces.

Judgment: Compliant

Regulation 17: Premises

The registered provider had not ensured the premises were in line with the statement of purpose and the floor plans for which it is registered. For example, there was a storage facility for hoists, wheelchairs and mobility aids located between toilet 22 and the lift, which was not displayed on the registered floor plans.

Inspectors also noted that the registered provider had not ensured that all areas of the premises conformed to the matters set out in Schedule 6 of the regulations; for example:

- There had been a leak in the roof over the link corridor connecting the Main House and the Grange Wing. While the provider was completing repair work related to this leak, one of the day spaces was seen to remain closed to residents during these works.
- The centre had experienced two heating breakdowns, affecting the Main House on 08 and 13 March 2026. The inspectors noted that the provider was awaiting a specialist review of this heating system, which had not occurred by the second inspection day. Following the inspection, the provider updated the Office of the Chief Inspector that recommended works were due to take place.
- The lock on the door of toilet 22 was broken and did not lock. This impacted the privacy of residents using this facility.
- Some parts of the centre were experiencing decorative wear and tear, for example, there was loose plaster in one bedroom and on ceilings, paint was seen peeling in some areas and worn carpet on the stairs which posed a trip hazard.
- There was moisture between the window panes in one bedroom, which impacted that resident's views from their window.
- Security lighting was poorly positioned as it was seen to cause a glare for residents watching television in the ground-floor day space facing the Main House. Two residents complained to the inspector about the lighting.
- The volume and management of the front-door alarm system affected residents' peaceful enjoyment of their environment. This alarm was heard operating loudly each time the front door opened, making the surrounding environment very noisy on numerous occasions throughout the inspection days.

Judgment: Not compliant

Regulation 18: Food and nutrition

The provider had not ensured that food and nutrition were delivered in line with the regulatory requirements. For example, over the course of the two-day inspection, several residents complained about the quality of the food, how it was cooked, the temperature at which it was served, and the portion sizes, which were not sufficient. Similar matters had been raised by residents in recent questionnaires and at

residents' committee meetings. Records reviewed found that in the fortnight prior to this inspection, the provider had held a targeted meeting with residents to discuss food-related concerns and agree on an action plan.

Judgment: Substantially compliant

Regulation 27: Infection control

The registered provider did not ensure that IPC procedures, consistent with the Authority's published standards, were in place and implemented by staff. For example:

- The sluice rooms did not support effective infection prevention and control, as evidenced by the following findings:
 - One of the sluice rooms had a shower hose facility for washing equipment. This was a repeat finding from a previous inspection. Using a shower hose increases the risk of contaminating surrounding surfaces and may spread infection.
 - The clean equipment rack in each sluice room contained items that were visibly dirty.
 - The sluice room in the Main House had no hand hygiene sink.
 - Some of the sluice rooms had no non-risk waste bins for waste disposal.
- Linen was not segregated in accordance with the provider's linen management policy. For example, the red linen skips were not being used for soiled and infectious linen to protect laundry staff from the spread of infection.
- Gaps in relation to IPC training have been referenced under Regulation 16: Training and staff development.

Judgment: Not compliant

Regulation 28: Fire precautions

While systems were in place to protect residents from the risk of fire, the arrangements in place to maintain the means of escape were inadequate, for example, the inspectors found seating, hoists, chair scales, wheelchairs and trolleys stored in escape corridors and stairwells throughout the premises. These practices posed a risk of obstructing these corridors and stairwells from being used as means of escape in an emergency. Escape routes must be kept free of obstruction and inappropriate storage.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

While comprehensive person-centred care plans were developed based on validated risk assessment tools, further action was required to fully comply with the requirements of the regulation, as outlined below.

- Of the seven care plans reviewed, there was no recorded evidence of consultation with the resident and, where appropriate, their family during care plan reviews.
- Inspectors found that one resident did not have a care plan prepared to accurately reflect the resident's assessed needs. For example, the resident was assessed as being at high risk of developing a pressure ulcer; however, there was no documented evidence of a care plan outlining this risk, nor the measures necessary to control it and enhance the resident's comfort and safety.
- Records reviewed found that several domains within residents' care plans, such as those concerning nutrition, communication, responsive behaviours, managing medical conditions and mobility and maintaining a safe environment, had not been updated at required intervals. Not updating residents' care plans meant that guidance concerning some aspects of residents' care needs were out of date or inaccurately recorded. For example, findings from mental health reviews conducted in 2023 and 2024 were used to guide the current care needs of a resident with responsive behaviours, while a falls risk assessment score referenced in a resident's care plan had not been updated to reflect an increase in that resident's falls risk.

Judgment: Not compliant

Regulation 8: Protection

While the registered provider had taken measures to protect residents from abuse, further action was required to ensure all abusive incidents were recognised and appropriately responded to. For example, one incident of alleged abuse had not been investigated as required by the regulations or managed in line with the provider's safeguarding policy. The practice of not investigating and managing incidents of abuse is a missed opportunity to identify potential risk factors which could place residents at further risk of abuse, to respond to residents' needs after an abusive incident has occurred, and to develop a robust safeguarding care plan that can mitigate the risk of further abuse and therefore enhance the residents' comfort and safety.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The inspectors found that residents' rights were upheld in the centre. Staff were seen to be respectful and courteous towards residents. Residents' privacy in their bedrooms was respected. The centre offered weekly in-house religious services.

Residents had access to radio, television and newspapers throughout the centre. Residents could communicate freely, having access to telephones, a designated computer and internet services throughout the centre. Residents had access to independent advocacy services.

Residents had facilities for occupation and recreation, as well as opportunities to participate in varied activities in accordance with their interests and capacities.

Residents had the opportunity to be consulted about and to participate in the organisation of the designated centre through regular residents' meetings and completing questionnaires. The inspectors found evidence that the provider hosted targeted meetings to address matters raised by residents during these committee meetings, including concerns about food.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ashbury Nursing Home OSV-0000007

Inspection ID: MON-0050037

Date of inspection: 19/03/2026

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The topic of call bell response times will be focused on at the staff safety huddles and brought up in department meetings as a focus point for the nursing home. In addition to this call bell audits will be enhanced and include live audits as well as historical audits through the call bell system. Nursing management will spot check with residents how they are finding response times to be and feedback will be sought via the residents committee through adding call bell response times to the standing agenda.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The staff training matrix will be updated to clarify that all IPC training is mandatory. This will ensure that the 33 staff who had completed the online training are included in having completed their IPC training. Additional in-person training will continue to be provided. A training session has been requested from our air mattress supplier which will cover proper use of the air mattresses specific to resident's clinical needs and weight. Spot checks and formal audits will commence on the use of air mattresses in the home also. Safeguarding and Fire training sessions have been booked to facilitate the re-education of staff whose training had lapsed. These sessions have commenced and are ongoing over the summer months. These are due to complete by the end of August. A new administrator has been recruited within the nursing home to assist in the maintenance of the training matrix and booking staff in to training. They are due to commence the post in August 2026.	

Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A training session has been requested from our air mattress supplier which will cover proper use of the air mattresses specific to resident's clinical needs and weight. Spot checks and formal audits will commence on the use of air mattresses in the home also. Education and training has been commenced in relation to the management of IPC and laundry. The staff training matrix will be updated to clarify that all IPC training is mandatory. This will ensure that the 33 staff who had completed the online training are included in having completed their IPC training. In addition to this there will be further IPC focussed audits including knowledge checks regarding MDRO status and environment. Knowledge on cleaning practices will also be checked by senior management. The upgrading works in the house will also increase cleaning storage and facilities in the home. A new system is rolling out to all staff for enhanced access to local policies including the management of residents who have fallen and skin integrity. This will allow staff to ensure they read and understand the policies and ask any questions should they need anything clarified. Staff nurses are also being met with in small groups for workshop style education on documentation and care planning. In addition to this, they will be educated about pressure area care and incident reporting to ensure the nursing home is a safe environment for residents, visitors and staff alike. There had been confusion in relation to reporting of NF06s due to the amendment to the health act which changed the wording around this notification. Clarity was provided by the inspector on the day of inspection which was later shared with the wider team to ensure that this does not occur again. The NF06 was submitted immediately on the evening of the inspection once this was clarified by the inspector. A back office is being created for nursing staff in the Main House of the nursing home to ensure that privacy is given to documentation. An audit tool has now been created to ensure GDPR compliance is maintained in these areas. Nurses have been assigned into tutorial groups for care planning and also for education on HIQA notifiable incidents to ensure timely escalation of same to nursing home management so that action plans can be created and the appropriate notification can be sent to HIQA within the regulatory timeframe. These will be complete by the end of August. In addition to the above the other action plans written for other regulations will assist the nursing home in becoming compliant for regulation 23.	

Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: The provider acknowledges that the required notifications were not submitted in accordance with the regulatory requirements. A review of these incidents identified that the omission arose from a misunderstanding of the notification requirements. It had been interpreted that incidents where residents remained within the boundary of the designated centre, including the enclosed car park, did not require notification to HIQA. This interpretation has now been clarified, and the provider recognises that these incidents should have been notified. Whilst not notified, all incidents were treated seriously by the local management of the home. A review was conducted for all incidents, and no residents came to harm. A reason for all incidents was found following these reviews and remedial was taken immediately to prevent reoccurrence. For example, one incident involved elopement through the secure garden. However, following investigation the perimeter gate could be left open. To rectify this an automatic closing mechanism and new keypad lock was installed. This ensures that the gate will remain closed and locked following use. It was also found that the wander system can be upgraded. This project has commenced and we await installation of the new system. Exit doors for the nursing home do alarm on the emergency bell system of the home and in one incident it was found that the sounding of this alarm had alerted staff to locate the resident immediately outside the exit door. These alarms remain in place. Existing measures to prevent reoccurrence of resident elopement include maglock keypad on all exit doors and gates. There is a wander system in place for the two main doors of the home (this is being upgraded) and residents at high risk of elopement can utilise this system in a dignified manner. NF05s have subsequently been reported to HIQA. In addition to the above, new measures have been introduced within the home to further safeguard our residents. An exit door checklist has been introduced to ensure the integrity of each exit door is maintained daily. A 30 minute location check has been commenced and this will be active for 48 hours for any resident who elopes or has a near miss elopement. This will be continued if indicated and escalation to the appropriate MDT member (e.g. GP or Psychiatry of Old Age) will be conducted if clinically indicated. In addition to this colleagues will be further educated via the nurse tutorial groups and elopement has been and will continue to be a focus of daily staff safety huddles. The NF06 notification was submitted immediately following clarification from the inspector during the inspection. The learning arising from this inspection has been shared with the wider management team to ensure a consistent approach across the service. The learnings about this have been shared with the management team and will also be addressed at the nurse tutorials.	

Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: A review of the registered floor plans has taken place and a meeting has been planned with the design team currently working on the premises upgrade in the nursing home. All corrections to the floor plan will be redrawn and the statement of purpose will be amended where applicable and these will be submitted to HIQA. The room which had the leak had to remain closed to residents for their safety. The leak was repaired and time was needed as per the builder to allow roof beams to dry prior to plastering and painting. This has now been completed and the room is in use again and being enjoyed by residents. Whilst no residents were harmed due to the heating failing, the provider has met with the third party company who manage the maintenance and repair of the heating system and has sought assurances that they will respond to call outs within three hours, seven days a week. A specialist review of the heating system has taken place since the inspection and all recommended works were completed. The lock on the door of toilet 22 was repaired on the day of inspection. A window fitting company has scoped for the repair of the failing glass and we await installation of this new window glass. A maintenance record log is kept which all staff have access to write issues in. In addition to this environmental audits have recommenced and the ongoing renovations and building works are being done to improve the premises and facilities at Ashbury Nursing Home. New blinds have been installed in the day space to ensure security lighting does not disrupt residents. A company has been sourced to install a new front wander door alarm system which will be quieter and more subtle whilst maintaining safety.	
Regulation 18: Food and nutrition	Substantially Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: New food probes were purchased to ensure accurate calibration. Food temperatures have been checked at all stages of the food serving process to ensure they are within acceptable parameters. Management will begin to witness this process ad-hoc to act as a second witness to the temperature. In addition to this the resident food forum noted that they do not have an issue with the quality of raw product being sourced by the home but a couple of residents disagreed with the preparation of it. Following this feedback the provider has met with the head chef and catering team to commence an action plan. This has already been actioned which includes changes to the soups available, cuts of meats and the offering of daily veg (in addition to seasonal veg) as requested by residents. The provider will then hold another food forum following dissemination of a food satisfaction survey to assess the success of the quality improvement initiative. Following this forum, the provider will meet with the catering team again if needed.	

Regulation 27: Infection control	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: The shower tray and hose will be removed. All urinal bottles have been replaced and new drip trays have been ordered. Spit checks of sluice rooms have commenced at various times of day. Non-risk waste bins have been added to sluice rooms and education and training has been commenced in relation to the management of laundry. The hand hygiene sink had been ordered and was installed on the second day of the inspection however we have now ordered a clinical hand hygiene sink to replace this one. Please see feedback from in relation to IPC training. In addition to this there will be further IPC focussed audits including knowledge checks regarding MDRO status and environment. Knowledge on cleaning practices will also be checked by senior management. The upgrading works in the house will also increase cleaning storage and facilities in the home.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: A new storage unit has been constructed for the storage of wheelchairs and trolleys. Hoists also have designated bays for storage. No equipment will be stored in the corridors when not in use. If items are temporarily on the corridor a one side system will be used. Increased auditing of storage will also take place by senior management. The existing seating has now been removed from the link corridor. This corridor is now completely clear of any potential obstacles and is kept under review.	
Regulation 5: Individual assessment and care plan	Not Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: The provider acknowledges the findings Under Regulation 5 and has undertaken a comprehensive review of all care planning processes. Immediate corrective actions have been implemented, and robust systems are now in place to ensure that all care plans are person-centred, accurate, regularly reviewed, and developed in consultation with residents and their families. Immediate corrective actions: A full review of identified non-compliances have been actioned and completed. A comprehensive reassessment has	

been completed. A person-centred care plan has now been developed addressing pressure ulcer risk, preventative interventions and comfort and safety measures.

Strengthening of Care Planning Processes: A structure care planning approach has been implemented which is based on validated risk assessments that clearly link assessment, risk, intervention and evaluation. Care plan development and review must include resident consultation and family involvement (where appropriate). Evidence is documented on Epic Care.

Ensuring accuracy and person-centred care: Alignment of care plans with assessed needs. All care plans reflect current clinical assessments. Care plans are specific to the individual resident's needs. Pressure ulcer risk have turning schedules and specialist equipment included in care plan. Fall risk care plans have mobility supports and supervision levels included in care plans.

High-Risk Care Plans: Priority is given to-pressure ulcer prevention, falls prevention, nutrition / hydration and responsive behaviours.

Review and updating of care plans: Scheduled reviews take place at least 4 monthly. Earlier if a change in condition, incident occurs or new risk identified.

Trigger-Based Reviews: care plans must be updated immediately following: falls, hospital admission, change in mobility / cognition, behavioural changes and any deterioration in a residents condition.

Electronic system alerts: Epic Care to flag overdue care plan reviews and alert staff to required updates.

Documentation recording Requirements: All care plans must be clear detailed and measurable and avoid vague or generic statements. Each care plan must include identified need, goal, interventions and evaluation.

Daily notes integration: Daily nursing notes must reflect delivery of care as per care plan and highlight any changes requiring review.

Staff re-education, training and competency: All nursing staff have completed training on person-centred care planning. This will be further enhanced with care plan workshops in small groups of 4-5 nurses to help link assessments to interventions and ensure documentation standards and care plans are completed in timeframes. Competency assessments of nurses are assessed on care plan quality and accuracy of documentation. DOO provided 1:1 supervision and guidance for all nurses. This will be overseen on an ongoing basis by PIC and DOO.

Governance and Oversight: Care plan audits to review care plan quality, review of consultation evidence and review of update frequency.

KPI's: 100% care plans to reflect current needs, have documented consultation and are reviewed within timeframes.

Clinical Governance Meetings: Care planning included as a standing agenda item. Monitoring includes audit findings, areas for improvement and action tracking.

Quality improvement measures: Learning from audit findings. Audit outcomes to identify trends and implement improvements. Continuous improvement from regular review of care planning systems and staff compliance.

Resident centred approach: Enhancing resident involvement so that residents are supported to participate in their care planning and express preferences and choices. Family engagement in consultation with resident consent. Families can be invited to care plan reviews and updated on changes.

Regulation 8: Protection	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 8: Protection:

The NF06 notification was submitted following an investigation following clarification from the inspector during the inspection. Findings were discussed with the complainant

and then closed. All allegations are treated seriously and investigated in local and national policy. The following measures were put in place following this incident: staff education on safeguarding concerns was reinforced at handovers as a safety topic and safety huddles. Safeguarding was added to the standing agenda of fortnightly clinical management meetings. Safeguarding of residents and the associated care plans for those requiring one has been added to the agenda for nursing tutorial groups.

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	31/10/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/10/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/10/2026
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and	Substantially Compliant	Yellow	31/10/2026

	needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.			
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/10/2026
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	31/10/2026
Regulation 23(1)(d)	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	31/10/2026
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures	Not Compliant	Orange	31/10/2026

	consistent with the standards published by the Authority are in place and are implemented by staff.			
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	31/10/2026
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	31/10/2026
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	31/10/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph	Not Compliant	Orange	31/10/2026

	(3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Substantially Compliant	Yellow	31/10/2026