<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Simpson’s Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0000096</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Ballinteer Road, Dundrum, Dublin 16.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 298 4322</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:info@simpsonhospital.org">info@simpsonhospital.org</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Board of Trustees, Simpson’s Hospital</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>John Curry</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Simon Balfe</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Deirdre Byrne</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>42</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>2</td>
</tr>
</tbody>
</table>
About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.

▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

▪ to monitor compliance with regulations and standards
▪ to carry out thematic inspections in respect of specific outcomes
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
Compliance with 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.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From: To:
28 May 2014 08:00 28 May 2014 18:30
29 May 2014 07:30 29 May 2014 15:00

The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome 01: Statement of Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 02: Contract for the Provision of Services</td>
</tr>
<tr>
<td>Outcome 03: Suitable Person in Charge</td>
</tr>
<tr>
<td>Outcome 04: Records and documentation to be kept at a designated centre</td>
</tr>
<tr>
<td>Outcome 05: Absence of the person in charge</td>
</tr>
<tr>
<td>Outcome 06: Safeguarding and Safety</td>
</tr>
<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
</tr>
<tr>
<td>Outcome 08: Medication Management</td>
</tr>
<tr>
<td>Outcome 09: Notification of Incidents</td>
</tr>
<tr>
<td>Outcome 10: Reviewing and improving the quality and safety of care</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
</tr>
<tr>
<td>Outcome 14: End of Life Care</td>
</tr>
<tr>
<td>Outcome 15: Food and Nutrition</td>
</tr>
<tr>
<td>Outcome 16: Residents Rights, Dignity and Consultation</td>
</tr>
<tr>
<td>Outcome 17: Residents clothing and personal property and possessions</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
</tr>
</tbody>
</table>

Summary of findings from this inspection

This monitoring inspection was carried out in response to an application from the provider to renew registration. As part of the monitoring inspection, the inspector met with residents, relatives and staff members. The providers of Simpson's Hospital are the Trustees of Simpson's Hospital. The person nominated on behalf of the provider is Mr. John Curry who is also the Chairman. Mr. Curry was unavailable to attend the inspection and the vice-chairman Mr. Liam Mulcahy met the inspector on the first day of the inspection. Mr. Curry was new to the role of provider and a fit person interview took place on 9 June 2014. The person in charge is Mr. Simon Balfe. Mr. Balfe had sat a fit person interview prior to the inspection process.
The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. The inspector also reviewed questionnaires submitted by residents and relatives during the inspection.

Overall, the inspector found that improvements were required in a number of areas in order to bring about substantial compliance with the requirements of 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.

The inspector found progress had been made to address some issues raised at the previous inspection. However, issues identified at the previous inspection in relation to fire safety, training of staff and the management of complaints had not been fully addressed. Other areas where improvements were required included the clinical leadership of the person in charge regarding the care planning process, restraint and falls management.

The inspector found evidence of improved practice in relation to aspects of risk management, and the recruitment of staff in the centre. There were good practices identified in relation to the privacy and dignity of residents' being met, and care provided by staff who were familiar with the residents' health care needs.

These issues are further discussed in the body of the report and in the Action Plan at the end of the report.
**Outcome 01: Statement of Purpose**

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
The inspector was satisfied the statement of purpose for the centre met the requirements of Regulation 5 and Schedule 1 of the Regulations. The services and facilities were outlined and the manner in which care was provided to residents in line with their needs.

**Judgement:**
Compliant

---

**Outcome 02: Contract for the Provision of Services**

Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
The inspector found improvements were required in the contract of care provided to residents.

A sample of written contracts of care reviewed were developed within the mandatory time frame for all residents'. The contracts of care set out the services to be provided. However, some improvements were identified as they did not fully meet the requirements of the Regulations. For example, contracts did not include the fees to be charged. The inspector noted a weekly levy of €15 was mandatory for additional services, yet the services were not outlined. Furthermore, residents could not opt out of paying the fee.
This was discussed with the centres administrator. The inspector was later shown a revised form that outlined the activities included in the extra charge, and it was planned to re-issue the contract to each resident.

**Judgement:**
Non Compliant - Minor

### Outcome 03: Suitable Person in Charge
*The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.*

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
While the requirements for the role of person in charge were met, with regard to qualifications and experience, improvements were required in relation to clinical governance and leadership of the person in charge in the centre.

The person in charge was a registered intellectual disability nurse, had the relevant necessary experience and worked full-time in the centre. However, the inspector observed a number of issues in relation to clinical governance and supervision which included aspects of health care such as falls and restraint management, as discussed under outcome 11. Additionally, improvements were required in relation to the care planning process and the implementation of an effective system of audits, as outlined under outcomes 10 and 11. The inspector found issues in relation to the clarification that all staff had received up-to-date training in mandatory areas as discussed in Outcome 18.

The person in charge had been in post since September 2013. He demonstrated knowledge in relation to a number of clinical areas and his responsibilities under the Regulations. The inspector found that he had participated in continued professional development. The person in charge had completed a management diploma. The person in charge stated that he maintained his professional development by attending in house clinical courses such as nutrition, and the inspector read documentary evidence that he had attended mandatory training in fire safety and manual handling.

The inspector noted that there were satisfactory deputising arrangements in place, with support provided by a clinical nurse manager (CNM). The CNM participated fully in the inspection process and demonstrated good clinical knowledge and a satisfactory understanding of her roles and responsibilities under the Regulations. The person in charge was also supported in his role by the provider and met with him formally at management meetings and weekly on an informal basis. He was supported by an
administrative staff who worked full-time in the centre and were responsible for managing non-clinical aspects of the service.

Judgement:
Non Compliant - Minor

Outcome 04: Records and documentation to be kept at a designated centre
The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
The inspector found that general and residents records were maintained in a manner to ensure completeness and accuracy and were easy of retrieve. However, improvements were required in relation to the review and implementation of operational policies.

There were centre specific policies developed in accordance with Schedule 5 of the Regulations. However, improvements were required to ensure policies guided practice and implemented by staff. For example, the medication and management of complaints policies were not up-to-date. These matters are discussed under outcomes 8 and 13. Whilst there were operational policies in place that provided comprehensive guidance to staff, they were not always reflected in practice. For example, the policies on the prevention of restraint, falls and nutrition. These are discussed under outcome 11.

There was a Residents Guide seen by the inspector. However, it did not include all information required by Regulations. For example, a copy of the contract of care. An updated version of the Residents Guide was submitted following the inspection that addressed this matter.

An up-to-date insurance policy was read that met the requirements of the regulations. The inspector found that medical records and other records, relating to residents and staff, were maintained in a secure manner.

Judgement:
Non Compliant - Moderate
**Outcome 05: Absence of the person in charge**
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
The provider was aware of the requirement to notify the Chief Inspector of any proposed absence of the person in charge for a period of more than 28 days. The provider had appropriate contingency plans in place to manage any such absence. A clinical nurse manager (CNM) deputised for the person in charge in his absence.

**Judgement:**
Compliant

---

**Outcome 06: Safeguarding and Safety**
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.

**Theme:**
Safe Care and Support

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
The inspector found systems were in place to protect residents from being harmed or suffering abuse. However, improvements were required in relation to the arrangements in place to safeguard residents' finances.

The inspector reviewed the arrangements in place to safeguard residents' finances held in safekeeping in the centre. There was a policy in place. However, it was not comprehensive enough to guide practice as there were no procedures to direct staff in transactions for external services paid by residents. For example, a sample of residents accounts were reviewed, and it was noted that cheques were paid for services carried out by external service providers yet there was no record of a staff and countersignature of the transaction. This matter were discussed with the administrator. A form was later shown to the inspector to ensure all transactions would be signed by staff.

All residents spoken to said they felt safe and secure in the centre. Residents stated that they attributed this to the staff who were caring and trustworthy. The training records
seen by the inspectors indicated some staff had received training on how to respond to an allegation of abuse. The inspector found that staff on duty on the days of inspection were knowledgeable with regard to their responsibilities in adult protection. There had been no instances, allegations or suspicions of abuse in the centre since the last inspection. However, the person in charge and the CNM were familiar with how to respond and investigate an allegation or suspicion of abuse in line with the centre's policy.

Judgement:
Non Compliant - Minor

**Outcome 07: Health and Safety and Risk Management**
The health and safety of residents, visitors and staff is promoted and protected.

**Theme:**
Safe Care and Support

**Outstanding requirement(s) from previous inspection:**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
The inspector was concerned in relation to the procedures in place for the management of fire safety. An area of improvement was also required in relation to risk management.

The administrator oversaw the role of fire safety officer in the centre, with responsibility for the prevention and detection of fire. The inspector was informed by the person in charge that either he or the administrator oversaw fire safety procedures in the event of the fire alarm going off. At the weekends and night time, a designated nurse oversaw the procedures in place. However, when the inspector spoke to staff, they were not familiar with these arrangements. For example, nurses who worked nights were not aware there was a delegated person at night or weekends and could not describe the procedures outlined by the person in charge. This was brought to the attention of the person in charge, who undertook to ensure all nurses were aware of the procedure.

The inspector saw records that confirmed fire drills were carried out every six months. These took place by an external consultant annually and by the administrator. The fire drill records included the outcome of each drill for learning purposes. However, improvements in the overall management of drills were required as they did not consistently include all staff on the day a drill was carried out. For example, records of drills read stated in some cases one staff member had taken part in the drill and in another, only the catering staff took part. This was brought to the attention of the person in charge and the administrator. The inspector was advised that drills would be reviewed and another was scheduled to take place on the 9 June 2014. Records were read that confirmed staff had up-to-date training. Staff were familiar with the fire evacuation procedures for the centre. There were regular checks of exits, alarm panels and fire doors. A daily check was carried out of the fire exits, this had been an action at
the previous inspection and was completed. The inspector was satisfied that all other fire arrangements were in line with the Regulations and promoted residents, staff and visitors safety.

There were health and safety and risk management policies in place which met the requirements of the Regulations. There was evidence that risks were identified and assessed. A risk register was seen. However, an area of improvement was identified. A small number of residents smoked in the centre. While regular risk assessments were completed, the actions to prevent the risks from smoking were not consistently outlined. The inspector visited the smoking room and appropriate control measures were in place. An area of risk identified at the last inspection in relation to the lift was now addressed and risk assessments for resident completed. The risk register had been updated to include this area of risk and a copy of the assessment was submitted to the inspector following the inspection.

An annual health and safety audit was carried out every year by the administrator. There were plans in place to carry these out every quarter. However, as reported in outcome 10, there was no evidence of the action taken to address the findings, or who was responsible. A maintenance man was contracted to regular checks and general maintenance checks.

The inspector was satisfied that policies and procedures on infection control were in place. Staff were due to carry out training in infection control in on the 5 and 17 June 2014. Disposable aprons, gloves and hand gel dispensers were available throughout the centre.

There were arrangements in place to manage adverse events or serious incidents involving residents. The inspector saw records of incidents and accidents were maintained. The person in charge reviewed all incidents, and a further analysis of the falls that occurred in the centre and presented a report on incidents each month to the board of the trustees. However, as outlined in outcome 11, improvements in the overall management of falls was required. Records read confirmed staff had received mandatory training. There was safe flooring provided. There were grab-rails in circulation areas. Handrails were provided in toilets, bath and shower areas.

A comprehensive emergency plan was read by the inspector which outlined the arrangements to be followed in the event of a fire, flood or gas leak. The staff were familiar with the policy, which was an action at the previous inspection and completed.

**Judgement:**
Non Compliant - Major

---

**Outcome 08: Medication Management**

*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**
Safe Care and Support
Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
The inspector found residents were protected by the centres comprehensive medication management policies and procedures. However, improvements were required in relation to information on the prescription sheets, and the procedures for the disposal of medications.

The medication policy reviewed by the inspector was comprehensive and guided practice. However, the pharmacy service for the centre had recently changed, and the details of the new service had not been included in the policy. This is outlined in outcome 4. The inspector read a sample of residents’ prescription and administration sheets. However, an area of improvement was required. For example, the prescription sheet for some residents did not contain the date of birth or the name of the general practitioner (GP). Additionally, the maximum dosage of an "as required" (PRN) medication to be administered in a 24 hours period was not prescribed.

The inspector found procedures were in place for the disposal of out of date or unused medications. However, there was no record maintained when medications were returned to the pharmacy.

Inspectors found that regular reviews of medication practices were undertaken, and there was evidence of three-monthly medication reviews by a GP which were recorded in residents' medical notes. Where errors had occurred an investigation was carried out along with details of the action taken and learning for staff. There were medication audits completed by the pharmacy every three months and monthly visits. The CNM reported internal audits were carried out, however, they were not documented and there was no evidence where had been action taken or if they had been was discussed at nursing meetings.

There were procedures in place for the storage and management of medications that required strict control measures (MDAs). Medications that needed temperature controls were safely stored in a locked refrigerator, with adequate controls measures in place.

The inspector did not see records for medication management training. Following the inspection details of training completed by staff in 2014 were submitted to the Authority. Additional training is planned in July 2014. Training is further discussed under outcome 18. The inspector spoke to staff and found them to be knowledgeable of the medication administration procedure.

Judgement:
Non Compliant - Minor
**Outcome 09: Notification of Incidents**  
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

**Theme:**  
Safe Care and Support

**Outstanding requirement(s) from previous inspection:**  
No actions were required from the previous inspection.

**Findings:**  
The inspector was satisfied that a record of all incidents occurring in the designated centre, were maintained and where required, notified to the Chief Inspector.

**Judgement:**  
Compliant

---

**Outcome 10: Reviewing and improving the quality and safety of care**  
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

**Theme:**  
Effective Care and Support

**Outstanding requirement(s) from previous inspection:**  
No actions were required from the previous inspection.

**Findings:**  
The inspector found there was a system in place to monitor and review the safety and quality of care of residents in the centre. However, it was not comprehensive enough to effect change or drive improvement.

The person in charge showed the inspector records of audits and reviews carried out in the centre. Audits included care planning, incidents, kitchen hygiene audit and health and safety audit. However, improvements were required, as there was no evidence of improvements made to enhance quality and safety of care in these areas. For example, although a care planning audit from November 2013 identified issues with the care plan process, the actions taken were not effective to drive improvement. This is discussed under Outcome 11. The inspector found residents were not consulted with in reviews and audits, and staff were not informed of the findings for learning purposes. Furthermore there was no formal plan in place to review other key performance indicators.

**Judgement:**  
Non Compliant - Moderate
Outcome 11: Health and Social Care Needs

Each residents wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each residents assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective Care and Support

Outstanding requirement(s) from previous inspection:
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The inspector found improvements were required in the overall quality and review of care plans for residents assessed needs, the documentation of care plans and consultation with residents. Additionally, significant improvements were required in the overall of management of falls prevention and the management of restraint.

Arrangements to meet residents’ assessed needs were set out in care plans based on a range of assessments which had been carried out at regular intervals. However, where residents were re-assessed they were not formally carried out and the quality of the review was not effective. For example, apart from a nurses signature and date no other information on the residents assessment was provided. Where care plans were developed for an identified need, in many cases the care plans did not guide the care to be delivered to residents. For example, in relation to falls, restraint, percutaneous endoscopic gastronomy (PEG), catheter care and activities. Furthermore, care plans were not consistently updated on a three monthly basis or following a change in circumstance. There was a large amount of historical data on the care plans making it difficult to find the most up-to-date intervention for residents. Furthermore, there was lack of evidence to show that residents were involved in their care plan. The inspector discussed these issues with the person in charge, who later provided a schedule of review for all care plans, it was anticipated that all care plans would be fully reviewed by the 8 August 2014.

The inspector was concerned that the practices in relation to the management of falls put residents at risk. There was a detailed falls policy in place that provided direction to staff. However, it was not implemented in practice in relation to post falls procedures. Where falls had occurred, there was inconsistent evidence that neurological observations were carried out following. The inspector saw residents were not routinely re-assessed after they had a fall and care plans were not updated after each fall. Furthermore, the falls care plans in place did not guide the care to be delivered and the interventions to be put in place to prevent similar falls occurring in the future. The inspector was concerned in relation to a resident who had multiple falls and whose care plans did not outline how to protect the resident and prevent more falls occurring. The person in
The person in charge undertook to address these issues and an updated care plan for the resident was submitted after the inspection.

The management of restraint required improvement. There was a policy on the use of restraint. However, it was not fully implemented in practice. For example, residents who used bed rails did not have a care plan developed. Where residents were assessed for the use of bed rails, the re-assessment was not formal and consisted only of a nurse signature and date. There were a low number of residents using bedrails and lap belts, out of 42 residents, 3 residents used bed rails and 1 resident used a lap belt. There was evidence of consultation with residents or their next of kin prior to the use of restraint. The inspector read records which confirmed restraint was monitored.

There were a small number of residents with behaviours that challenged. However, inspectors found inconsistent practices meant not all residents’ needs were met. While a policy was in place to guide practice, it was not fully implemented to ensure consistency of care for all residents. For example, the care plan did not outline the triggers of the behaviours and the strategies to be carried to minimize the challenging behaviour. This was discussed with the person in charge, who was knowledgeable of the residents and outlined plans to address this area of need. Furthermore, he was researching training in behaviours that challenge which he hoped to implement in the near future.

The inspector reviewed the practices in the management of nutrition. A comprehensive nutrition and hydration policy was in place. However, an area of improvement was identified. For example, the recommendations of the speech and language therapist for one resident had not been incorporated into one resident's care plan. This was discussed with the CNM and person in charge who undertook to address the matter. The inspector saw residents' nutritional needs were regularly reviewed and care plans were developed where a need was identified.

The inspector found good practices in the management of wound care. There were no wounds at the time of the inspection. Staff were familiar with wound care procedures.

Residents' health care needs were supported by good access to GP services and an out-of-hours GP service was also available. The inspector found health care staff were knowledgeable of the residents' health care needs. The residents had access to a range of allied health professionals for example, dietician, speech and language therapist and psychiatric services. Letters of referrals and appointments were seen on residents' files.

The inspector found that the person in charge ensured residents' social care needs were met and systems were in place to ensure the residents had interesting things to do during the day. However, the social care needs of residents who were unwilling or unable to participate in activities required improvement. Additionally, an increasing number of residents had a dementia in the centre and were unable to take part in activities as a result of their cognitive impairment. The residents were assessed and there were care plans in place. However, the care plans did not clearly outline the residents' likes, dislikes and interests. This was discussed with the activities coordinator, who was very familiar with the residents and their social care needs. She acknowledged it could be an area of improvement. The activities coordinator had completed training in sonas (a therapeutic programme for people with communication challenges).
Inspector noted activities took place throughout the day in a number of areas that included group activities such as an exercise class, board games, arts and crafts, bingo, and on other days, there music sessions and prayers was facilitated. There was a programme of activities displayed in the hallway and outside the sitting areas which outlined the daily activities provided for residents.

Judgement:
Non Compliant - Major

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Care and Support

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
The inspector was satisfied that the centre was well maintained both internally and externally. It was found to be clean and comfortable.

The centre was divided between the old house and a more modern building which housed the residents bedrooms. It is located over two floors. The inspector found residents bedrooms were clean, bright and had sufficient storage space. The rooms were comfortably furnished with domestic style curtains and bed linen. Most bedrooms were single, with a number of twin bedrooms. There were sufficient number of toilets with wash hand basin, and bath and shower facilities. There were a sufficient number of wheelchair accessible toilets and showers and baths for use.

There was an adequate provision of toilets near the communal areas which were wheelchair accessible. There was suitable and sufficient communal space for residents. There were a number of sitting areas and a dining room, along with a private meeting room and a large day room. The corridors were wide and spacious with grab rails and hand rails throughout. Many residents were observed sitting in the day rooms watching televisions or chatting with visitors.

Safe and secure garden space was available, directly accessible from the centre. The centre was located on large grounds with nicely landscaped areas. Appropriate assistive equipment was provided to meets residents’ needs such as hoists, seating, specialised beds and mattresses. The inspector viewed the servicing records and maintenance records for equipment and found they were up-to-date.
Appropriate arrangements were in place for the disposal of clinical waste. There was a sluice room which was equipped with bedpan washers.

A high level of cleanliness and hygiene was maintained in the centre. Cleaning equipment was appropriately stored. Staff adhered to best practice in cleaning, for example, the colour coding of cleaning cloths for different areas of the centre. Appropriate changing facilities were provided for all staff.

**Judgement:**
Compliant

---

**Outcome 13: Complaints procedures**
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection:**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
The inspector found the overall management of complaints in the centre required improvement.

There was no procedure displayed in the centre to inform residents, visitors and staff on the management of complaints. The inspector brought this to the attention of the person in charge and a procedure was later shown to the inspector, and put on display. However, this document had not been drawn up in line with the requirements of the Regulations as the complaints officer was not clearly identified and it did not identify an independent person to oversee the complaints process.

There was no up-to-date policy on the management of complaints that guided practice. Two policies were reviewed by the inspector. One had been submitted to the Authority prior to the inspection and contained the named complaints officer. However, a complaints policy reviewed by the inspector during the inspection differed to the one that had been submitted prior to the inspection. For example, it was not up-to-date and did not include the named complaints officer for the centre.

The inspector reviewed the complaints log. There was evidence that written complaints had been investigated along with the satisfaction of the complainant. However, there was no record of verbal complaints made in the centre or their investigation. This had been an action at the previous inspection and was not addressed.

**Judgement:**
**Outcome 14: End of Life Care**
*Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.*

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
The inspector found improvements were required in the management of residents' needs who were approaching end of life.

While there was a comprehensive policy on end-of-life care which had been recently reviewed by the person in charge following training in this area. However, it was not fully implemented in practice to ensure care plans developed included residents' spiritual and religious needs. For example, a sample of care plans reviewed did not outline residents' religious and cultural needs in their care plan.

There was access to the services of a palliative care team if required, and some staff had received training in this area. A visitor's room was available for relatives and friends for privacy if and when required.

**Judgement:**
Non Compliant - Minor

---

**Outcome 15: Food and Nutrition**
*Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.*

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
The inspector found resident's were provided with meals that were wholesome and in accordance with their assessed needs. Residents’ dietary requirements were met to a good standard.
The inspector spent time with residents in the dining room at lunch time and found residents were discreetly and respectfully assisted with their meals where required. There was a menu which outlined the choices at mealtime, and whilst it was displayed on the wall of the dining room, the inspector noted it was not fully accessible to all residents. The inspector was informed by some residents they did not know there was a menu or what was on the menu for the week. This was discussed with the person in charge and CNM who agreed to address the matter. The staff were familiar with the special dietary requirements and preferences of residents’ and, were knowledgeable of the residents’ assessed needs. There was a four-week rolling menu which was reviewed by the chef along with the dietician to ensure quality meals and choice at meal times.

The inspector saw residents being offered a variety of snacks and fresh water, fruit juices and hot drinks during the day.

Judgement:
Compliant

**Outcome 16: Residents Rights, Dignity and Consultation**
Residents are consulted with and participate in the organisation of the centre. Each residents privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.

Theme:
Person-centred care and support

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
The inspector found residents were consulted with and participated in the organization of the centre. However, an area of improvement was required in this area.

There were arrangements in place to facilitate consultation and participation with residents in the organisation of the centre. However, the inspector noted they were infrequently held. For example, there were gaps of eight months between meetings. The last meeting was held in April 2014, and the minutes read confirmed a range of issues were discussed and raised by residents, and were addressed by the person in charge.

Religious and spiritual needs of residents were respected. The person in charge outlined the services available to the residents. Mass was celebrated in the centre every week.

Throughout the inspection staff were friendly and personable to residents. The residents seemed comfortable and happy in their surroundings. The inspector spoke to a number of residents, families and staff and all expressed their satisfaction with the centre.
Communication needs were facilitated. The residents had access to a telephone on each floor. There were televisions provided and available in each bedroom. The newspapers were available each day including weekends.

The provider and person in charge ensured residents voting rights were maintained. The residents were supported to attend a local polling station at each election, and a polling booth was also set up in the centre if residents wished to cast their vote. A number of residents confirmed with the inspector that they had voted in the recent local and European elections.

Judgement: 
Non Compliant - Minor

**Outcome 17: Residents clothing and personal property and possessions**
Adequate space is provided for residents personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
The inspector found residents had sufficient space for their personal belongings and their clothes were suitably laundered and returned to them.

The inspector observed and residents confirmed, that they were encouraged to personalise their rooms. There was a record of residents personal belongings maintained on their file. However, it was not kept up-to-date. This was discussed with the administrator, who showed the inspector a proposed form to use when reviewing residents personal belongings list. Many of the bedrooms were decorated with pictures and photographs from residents’ own homes. Residents had private lockable space to store personal valuables.

Clothing items were clearly marked with the name of the resident. An external company carried out a laundry service. The inspector talked to residents who confirmed they were satisfied with the way in which their clothes were cared for and were happy with the service. It was noted that where issues with clothing had been raised, they had been appropriately dealt with through the complaints process.

Judgement:
Non Compliant - Minor
Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Workforce

Outstanding requirement(s) from previous inspection:
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The inspector found there were good practices in place for the recruitment of staff and there was an adequate staff and skill mix on the day of the inspection. However, improvements were required in the maintenance of staff training records and procedures in place for volunteers and external service providers.

There was a procedure in place to monitor staff training. However, it was not kept up-to-date. For example, there was a 2012-2103 programme in place but it was not continued for 2014. Therefore it was difficult to ascertain who had up-to-date training in fire safety and prevention and manual handling. This had been an action at the previous inspection and was not fully completed.

A number of volunteers provided a valuable service to residents in the centre. Appropriate An Garda Síochána and a written agreement was in place. However, external service providers who regularly visited the centre had not been vetted and had no agreement of their roles in place. This was discussed with the administrator who undertook to ensure this would be addressed.

The inspector found there were adequate staff and skill mix on the day of the inspection. The person in charge ensured that new staff were suitably inducted, and a formal induction programme had been put in place since the last inspection. The inspector saw a copy of the induction programme and checklists were completed by staff during their probationary period. The person in charge was in the process of introducing a system of performance review and supervision meetings with staff. Three staff had been through the process to date, with plans to ensure all staff had a review and supervision meeting completed on an annual basis.

There was a recruitment policy in place that provided direction to staff. The inspector reviewed a sample of staff files and they contained all of the information required by Schedule 2 of the Regulations. The action in relation to this from the previous inspection had been addressed. There were copies of each nurses registration details with An Bord Altranais agus Cnaimhseachais na hEirneann (Nursing and Midwifery Board of Ireland) for 2014.
Judgement:
Non Compliant - Minor

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Deirdre Byrne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Simpson's Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0000096</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>28/05/2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>23/06/2014</td>
</tr>
</tbody>
</table>

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure Compliance with 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.

Outcome 02: Contract for the Provision of Services

Theme:
Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The contract of care did not include details of the fees charged and, the details of the services which incurred an additional cost.

Action Required:
Under Regulation 28 (2) you are required to: Ensure each residents contract deals with the care and welfare of the resident in the designated centre and includes details of the services to be provided for that resident and the fees to be charged.

Please state the actions you have taken or are planning to take:
The contract of care has been updated to include details of fees charged and, the details of the services provided for these fees.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
A letter has been given to all residents/relatives setting out the details of the fees charged.

**Proposed Timescale:** 27/06/2014

**Outcome 03: Suitable Person in Charge**

**Theme:**
Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were improvements required in the clinical leadership and governance provided by the person in charge.

**Action Required:**
Under Regulation 15 (1) you are required to: Put in place a person in charge of the designated centre.

**Please state the actions you have taken or are planning to take:**
All resident’s care plans will be reviewed and updated accordingly as per the schedule given to the inspector on the 29th May 2014.

The Person in Charge has developed a Clinical Governance Audit Action Plan into which all audits conducted in the hospital will feed and actions required following these audits will be recorded.

**Proposed Timescale:** 08/08/2014

**Outcome 04: Records and documentation to be kept at a designated centre**

**Theme:**
Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Not all policies were up-to-date, for example, the complaints policy.

Not all policies were reflected in practice by staff such as the prevention of falls policy.

**Action Required:**
Under Regulation 27 (2) you are required to: Review all the written operational policies and procedures of the designated centre on the recommendation of the Chief Inspector and at least every three years.
Please state the actions you have taken or are planning to take:
The Complaints Policy has been updated. The complaints policy and procedure was
discussed at a resident’s council meeting held on the 12th June 2014.

The Falls Policy was discussed with staff to ensure that the policy is reflected in
practice.

Proposed Timescale: 20/06/2014

Outcome 06: Safeguarding and Safety
Theme:
Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were improvements required in the safeguarding arrangements of residents
finances.

Action Required:
Under Regulation 6 (1) (a) you are required to: Put in place all reasonable measures to
protect each resident from all forms of abuse.

Please state the actions you have taken or are planning to take:
The procedures for safeguarding resident’s finances were revised on the 28th May and
shown to the inspector.

Proposed Timescale: 28/05/2014

Outcome 07: Health and Safety and Risk Management
Theme:
Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Where risks have been identified and assessed the control measures to manage the risk
are not been clearly outlined, for example, the risk of smoking.

Action Required:
Under Regulation 31 (2) (a) and (b) you are required to: Ensure that the risk
management policy covers, but is not limited to, the identification and assessment of
risks throughout the designated centre and the precautions in place to control the risks
identified.
**Please state the actions you have taken or are planning to take:**
Smoking risk assessments have been updated and completed by the Person in Charge for the resident’s concerned.

---

**Proposed Timescale:** 20/06/2014

**Theme:**
Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Fire drills carried out in the centre required review.

**Action Required:**
Under Regulation 32 (1) (e) you are required to: Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.

**Please state the actions you have taken or are planning to take:**
Following the inspection we reviewed the format of our fire drills with our external fire safety provider. We are satisfied that the hospital’s fire drills are conducted in accordance with legislation and regulation. We will continue to review all aspects of fire safety management in conjunction with external expert consultants.

As part of our ongoing fire safety management programme scheduled fire drills with staff commenced on the 9th June 2014.

---

**Proposed Timescale:** 09/06/2014

**Theme:**
Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some staff did not demonstrate knowledge of what to do in the event of a fire.

**Action Required:**
Under Regulation 32 (1) (d) you are required to: Provide suitable training for staff in fire prevention.

**Please state the actions you have taken or are planning to take:**
All staff in Simpson’s receive annual fire training by an external service provider and separate internal fire procedures training which includes a fire drill.

The nurses are being provided with additional training in their responsibility as Person in Charge.
Proposed Timescale: 27/06/2014

**Outcome 08: Medication Management**

**Theme:**
Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The maximum dosage of PRN medication in a 24 hour period was not prescribed.

Some prescriptions sheets did not contain residents date of birth and GP name.

**Action Required:**
Under Regulation 33 (1) you are required to: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

**Please state the actions you have taken or are planning to take:**
The maxim dosage of PRN medications is being reviewed by the residents’ GP.

All prescription sheets have now been updated to include date of birth and name of GP.

Proposed Timescale: 11/07/2014

**Theme:**
Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records of unused medications that are to be returned to the pharmacy are not maintained.

**Action Required:**
Under Regulation 33 (2) you are required to: Put in place suitable arrangements and appropriate procedures and written policies in accordance with current regulations, guidelines and legislation for the handling and disposal of unused or out of date medicines and ensure staff are familiar with such procedures and policies.

**Please state the actions you have taken or are planning to take:**
All nursing staff have been given refresher training regarding the procedures for the return of unused medication as per the hospital’s Medication Management Policy.

Proposed Timescale: 20/06/2014
### Outcome 10: Reviewing and improving the quality and safety of care

**Theme:**
Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The system of audit of quality and safety issues was not effective to improve the service.

**Action Required:**
Under Regulation 35 (1) (b) you are required to: Establish and maintain a system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.

**Please state the actions you have taken or are planning to take:**
The Person in Charge has developed a Clinical Governance Audit Action Plan into which all audits conducted in the hospital will feed and actions required following these audits will be recorded.

**Proposed Timescale:** 27/06/2014

### Outcome 11: Health and Social Care Needs

**Theme:**
Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The social care needs of residents with a cognitive impairment were not fully met.

**Action Required:**
Under Regulation 6 (3) (d) you are required to: Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.

**Please state the actions you have taken or are planning to take:**
The hospital's activity co-ordinator will lead a review of the social care needs of residents with cognitive impairment. This review will be tasked with providing opportunities for each resident to participate in activities appropriate to his/her interests and capabilities.

**Proposed Timescale:** 01/08/2014
Theme: Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvements were required in relation to aspects of health care, such as the management of falls, restraint and behaviours that challenge.

Action Required:
Under Regulation 6 (3) (a) you are required to: Put in place suitable and sufficient care to maintain each residents welfare and wellbeing, having regard to the nature and extent of each residents dependency and needs.

Please state the actions you have taken or are planning to take:
All resident’s care plans will be reviewed and updated accordingly as per the schedule given to the inspector on the 29th May 2014. Specifically in the area of Falls and Restraint the following is being carried out:

Falls
All falls will be reviewed monthly at the Clinical Governance meeting. Staff will be required to re-read and implement procedures identified in the Falls Policy.
- After each fall a resident will be routinely re-assessed and care plans will be updated in conjunction with the resident and or family member to include if required the following:
  - Assessed by GP and Physio
  - Ensure bed alarm is in situ
  - Keep bed in lowest position
  - Place crash mat on floor
  - Ensure call bells are within reach and encourage to use same
  - Implement visual observations
  - Evaluate frequency and time of falls
  - Discuss with GP and Physio, if it is decided that a restraint (bed rails) are required carry out proper assessment
  - Assess environment to maximise safety i.e. furniture, lighting

Restraint
All staff are required to re-read the Restraint Policy and follow the procedures and guidelines stated in the policy. Resident’s will be routinely re-assessed and care plans will be updated in conjunction with the resident and or family member.
- Restraint should only be used when all other nursing interventions / alternatives have failed:
  - Ensure bed alarm is in situ
  - Keep bed in lowest position
  - Place crash mat on floor
  - Ensure call bells are within reach and encourage to use same
  - Implement visual observations
  - The decision to use a restraint should be made in consultation with the multi-disciplinary team that includes doctors, nurses,
physiotherapists, resident (if possible) and family.
o All restraint use will be reviewed by the Clinical Governance team and signed off by same.
o All restraints should be used for the shortest time possible.
o Integrating diversional activities as part of the care plan for the older person may help in managing the avoidance of restraint.

Simpson’s Hospital strives to be restraint free and will continue to assess Residents who require restraints and seek alternatives.

**Proposed Timescale:** 08/08/2014

**Theme:**
Effective Care and Support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A nursing assessments of residents health and social care were not consistently reviewed regularly to identify changing needs for residents.

**Action Required:**
Under Regulation 8 (2) (b) you are required to: Keep each residents care plan under formal review as required by the residents changing needs or circumstances and no less frequent than at 3-monthly intervals.

**Please state the actions you have taken or are planning to take:**
All resident’s care plans will be reviewed and updated accordingly as per the schedule given to the inspector on the 29th May 2014.

**Proposed Timescale:** 08/08/2014

**Theme:**
Effective Care and Support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Care plans are not consistently reviewed regularly to reflect the current status of the residents.

**Action Required:**
Under Regulation 8 (1) you are required to: Set out each resident’s needs in an individual care plan developed and agreed with the resident.

**Please state the actions you have taken or are planning to take:**
All resident’s care plans will be reviewed and updated accordingly as per the schedule given to the inspector on the 29th May 2014.
<table>
<thead>
<tr>
<th>Proposed Timescale: 08/08/2014</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Effective Care and Support</td>
<td></td>
</tr>
<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong> Residents were not consulted with or involved in their care plan.</td>
<td></td>
</tr>
<tr>
<td><strong>Action Required:</strong> Under Regulation 8 (2) (c) you are required to: Revise each residents care plan, after consultation with him/her.</td>
<td></td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong> The Person in Charge has developed a Multi-Disciplinary Team Form which includes a section for residents/relatives to sign as part of the review of the care plan.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proposed Timescale: 08/08/2014</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Effective Care and Support</td>
<td></td>
</tr>
<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong> Care plans were not developed for all identified needs for example, the use of bedrails.</td>
<td></td>
</tr>
<tr>
<td><strong>Action Required:</strong> Under Regulation 8 (1) you are required to: Set out each resident’s needs in an individual care plan developed and agreed with the resident.</td>
<td></td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong> All resident’s care plans will be reviewed and updated accordingly as per the schedule given to the inspector on the 29th May 2014.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proposed Timescale: 08/08/2014</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Effective Care and Support</td>
<td></td>
</tr>
<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong> The most up-to-date recommendations of a SLT were not incorporated into some residents care plans.</td>
<td></td>
</tr>
<tr>
<td><strong>Action Required:</strong> Under Regulation 8 (1) you are required to: Set out each resident’s needs in an individual care plan developed and agreed with the resident.</td>
<td></td>
</tr>
</tbody>
</table>
Please state the actions you have taken or are planning to take:
The resident’s care plan has been updated to include the recommendations of the SLT.

**Proposed Timescale:** 20/06/2014

### Outcome 13: Complaints procedures

**Theme:**
Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The policy on the management of complaints was not up-to-date and did not meet the requirement of the Regulations.

**Action Required:**
Under Regulation 39 (1) you are required to: Provide written operational policies and procedures relating to the making, handling and investigation of complaints from any person about any aspects of service, care and treatment provided in, or on behalf of a designated centre.

**Please state the actions you have taken or are planning to take:**
The hospital’s Complaints Policy was reviewed and updated.

**Proposed Timescale:** 29/05/2014

**Theme:**
Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no complaints policy displayed in the centre.

**Action Required:**
Under Regulation 39 (4) you are required to: Display the complaints procedure in a prominent position in the designated centre.

**Please state the actions you have taken or are planning to take:**
The complaints procedure is now displayed throughout the centre. The procedure for making complaints was explained and discussed at the residents’ council meeting on the 12th June 2014.

**Proposed Timescale:** 12/06/2014
**Theme:**  
Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
There was no record of verbal complaints made in the centre.

**Action Required:**  
Under Regulation 39 (7) you are required to: Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.

**Please state the actions you have taken or are planning to take:**  
A verbal complaints log book is now in use. Staff have been notified of the log book and have been given instruction in its use.

**Proposed Timescale:** 11/06/2014

---

**Outcome 14: End of Life Care**

**Theme:**  
Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Care plans do not fully direct the care to be delivered in end-of-life.

**Action Required:**  
Under Regulation 14 (2) (a) you are required to: Provide appropriate care and comfort to each resident approaching end of life to address his/her physical, emotional, psychological and spiritual needs.

**Please state the actions you have taken or are planning to take:**  
All resident’s care plans will be reviewed and updated accordingly as per the schedule given to the inspector on the 29th May 2014.

**Proposed Timescale:** 08/08/2014

---

**Outcome 16: Residents Rights, Dignity and Consultation**

**Theme:**  
Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The residents committees did not meet with suitable frequency to ensure residents fully participated in the organisation of the centre.
Action Required:
Under Regulation 10 (g) you are required to: Put in place arrangements to facilitate residents consultation and participation in the organisation of the designated centre.

Please state the actions you have taken or are planning to take:
Resident’s Council meetings will now take place monthly. The last meeting was held on the 12th June and the next meeting will be held on the 17th July. A schedule of the meetings for the rest of the year has been completed.

Proposed Timescale: 12/06/2014

Outcome 17: Residents clothing and personal property and possessions

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The records of residents’ personal property are not up-to-date.

Action Required:
Under Regulation 7 (2) you are required to: Maintain an up to date record of each residents personal property that is signed by the resident.

Please state the actions you have taken or are planning to take:
The Person in Charge will delegate a member of staff to update the residents’ personal property record on a 6 monthly basis.

Proposed Timescale: 01/08/2014

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The system in place to ensure all staff had up-to-date mandatory training required improvement.

Action Required:
Under Regulation 17 (1) you are required to: Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence based practice.
| Please state the actions you have taken or are planning to take: |
| A new staff training matrix has been developed to ensure that all staff training requirements are being met. |

**Proposed Timescale:** 20/06/2014

**Theme:**  Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A number of external service providers did not have their roles set out in a written agreement.

**Action Required:**
Under Regulation 34 (a) you are required to: Set out the roles and responsibilities of volunteers working in the designated centre in a written agreement between the designated centre and the individual.

**Please state the actions you have taken or are planning to take:**
A written service agreement has been developed for the one external service provider concerned.

**Proposed Timescale:** 04/07/2014

**Theme:**  Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A number of external service providers had not been Garda vetted.

**Action Required:**
Under Regulation 34 (c) you are required to: Ensure volunteers working in the designated centre are vetted appropriate to their role and level of involvement in the designated centre.

**Please state the actions you have taken or are planning to take:**
The one external service provider concerned has completed a Garda Vetting form.

**Proposed Timescale:** 01/08/2014