Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Simpson's Hospital
Name of provider:	Trustees of Simpson's Hospital
Address of centre:	Ballinteer Road, Dundrum, Dublin 16
Type of inspection:	Unannounced
Date of inspection:	15 May 2024
Centre ID:	OSV-0000096
Fieldwork ID:	MON-0042493

About the designated centre

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

Simpson's hospital is a 48 bedded Nursing Home, located in Dundrum and provides long term residential care for men and women over 65 years of age. Since its foundation in 1779, Simpson’s Hospital has cared for older persons from all walks of life and religious denominations. Simpson’s Hospital is governed by a voluntary Board of Trustees. It has 30 single and nine double rooms located over two floors which are serviced by an assisted lift. The newer part of the building has a bright sunny seating area which links the original and new buildings. All bedrooms have under floor heating, full length windows and electric profiling beds. All en-suite bedrooms have assisted showers. The centres day space and dining room are located in main building, which has many original features. The ethos of Simpson’s Hospital is centred around the provision of person centred care within a culture of continuous quality improvement. Simpson's Hospital strives to create a homely, relaxed and friendly atmosphere in a modern state of the art facility.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	48

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 15 May 2024	08:15hrs to 16:30hrs	Niamh Moore	Lead
Thursday 16 May 2024	08:30hrs to 15:50hrs	Niamh Moore	Lead
Wednesday 15 May 2024	08:15hrs to 16:30hrs	Frank Barrett	Support
Thursday 16 May 2024	08:30hrs to 15:50hrs	Karen McMahon	Support

What residents told us and what inspectors observed

This inspection took place over two days in Simpson's Hospital in Dundrum, Dublin 16. Throughout both days, the inspectors spoke with a number of residents living in the centre. Residents spoken with gave positive feedback regarding their life and the care they received in the centre. The overall feedback from residents was that management and staff were kind and caring. Residents informed inspectors that they felt safe within the centre, enjoyed the food and were happy with the responsiveness of staff and the cleanliness of their bedrooms.

The centre was laid out over an older building and an extension of a newer wing. The new wing contained residents' bedroom accommodation. The older building contained communal spaces such as day rooms, the dining room, a visitor's room and services for the nursing home, such as the kitchen, laundry and staff changing areas. Inspectors found that the older part of the premises required ongoing maintenance. This will be further discussed within the report.

The centre provided accommodation for 48 residents in 30 single and nine twin bedrooms. Residents had access to en-suites. A number of residents' bedrooms were viewed and were seen to have been personalised with furniture, family photographs, ornaments and decorative items, including throws and cushions. Many residents said they were happy with their bedrooms.

Inspectors observed that staff and resident interactions were person-centred and respectful. Residents had access to television, phones and newspapers. There was an activity schedule available and it was on display in the designated centre. It detailed the variety of activities on offer each day such as manicures, a fit for life exercise class, art, Mass, music, brain teasers and crafting. Residents told inspectors that they enjoyed attending the activities on offer. Inspectors observed that residents were supported to enjoy the sunshine in the gardens throughout the inspection days.

There was evidence that feedback raised from residents through the complaints process or within council meetings were being addressed. For example, recent issues were raised with the laundry service in relation to items being damaged or not being returned. Inspectors saw evidence that the person in charge held a meeting with the external laundry provider to address these issues, with an action plan developed and a follow up meeting scheduled for the week following this inspection.

The menu was on display on tables within the dining room. An inspector observed the lunch time service on the first day of the inspection. Residents were provided with a choice of meals which consisted of roast chicken and bacon or baked salmon, while dessert options included chocolate mousse or ice-cream. There was also two choices for the tea-time meal. There were enough staff available to assist residents with their meals and meals were observed to be well presented. Condiments were

available on tables and residents where able, were seen to have their independence promoted. Residents reported to enjoy the meals and were particularly happy to have the menus on display.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects 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

The Trustees of Simpson's Hospital is the registered provider for Simpson's Hospital. This was an unannounced inspection completed over two days to review compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People Regulations 2013). Overall, the inspectors found that the registered provider was striving to improve compliance with the regulations. Improvements had been made since the last risk inspection of November 2023 particularly to management oversight in the area of care planning and restrictive practices. However, some further improvements to the management systems was required to ensure effective oversight of all areas.

There had been changes to the governance structure since the last risk inspection of November 2023. A new person in charge was appointed in February 2024.The person in charge facilitated this inspection and was seen to be well-known to the residents and staff team of the designated centre. The person in charge was supported in their role by an administration team and a clinical nurse manager. Other staff included nurses, healthcare assistants, housekeeping, catering, activity staff and a volunteer.

Inspectors found that the staffing levels and skill-mix of clinical staff were sufficient to meet the assessed needs of the 48 residents on the day of inspection, including a minimum of two registered nurses working day and night. However, inspectors were not assured that the numbers of housekeeping staff was sufficient to meet the cleaning requirements of the service given the size and layout of the designated centre. This is further evidenced under Regulation 27: Infection Control.

Overall mandatory training provided to staff was up-to-date, however inspectors were not assured that some trainings were sufficiently comprehensive as outlined under Regulation 16: Training and Staff Development. There was supplementary training provided to staff in areas such as a human rights-based approach and restrictive practices. In addition, all nurses had attended training on medication management. There was evidence of informal supervision taking place through the oversight of allocated tasks. In addition, there was supervision of staff through induction forms and annual appraisals.

While overall records were readily available throughout the inspection. Inspectors reviewed staff files and found that some did not contain all the information as required by Schedule 2. However, management had completed an audit of staff files and inspectors saw that the registered provider had identified the relevant action with a timebound plan to respond to all the areas for improvement.

While there was evidence of some good management systems in place such as board and management meetings, monitoring clinical data, auditing of key areas of care and a risk register. Inspectors saw that audits with an area for improvement identified were then re-audited to ensure the necessary follow up was actioned. For example, a care plan audit found 80 percent compliance, this was then re audited two weeks later and recorded the necessary actions were taken and therefore the audit result was 100 percent. This inspection agreed with these findings with appropriate care planning found under Regulation 5: Individualised Assessment and Care plan. Inspectors noted that the person in charge was in post for less than four months but was also identifying further areas for improvement such as in-person training in lieu of online training. Despite these good measures in place, inspectors found that further oversight was required to ensure there was evidence of progression of all required improvements, for example in relation to safeguarding. This is further outlined under Regulation 23: Governance and Management.

Inspectors saw that a record of all notifiable incidents occurring in the designated centre was maintained, however a number of incidents had not been recognised as safeguarding concerns and therefore the relevant notifications, as set out in Schedule 4 of the regulations, had not been submitted to the Chief Inspector.

A fire safety risk assessment had been carried out at the premises by a competent contractor in February 2023. This risk assessment found deficits in areas of fire safety including electrical, compartmentation and fire doors, which required action to be completed within the set time frame ranging from 24hrs to one month. On the day of inspection, some work was progressing in relation to compartmentation works, however, significant findings persisted in relation to compartmentation, fire doors, and electrical installations. Fire safety oversight and management is discussed further under Regulation 23: Governance and Management, and general fire safety considerations are discussed under Regulation 28: Fire Precautions.

There was a complaints policy in place that was reflective of regulatory requirements. There was information about the complaints process displayed on notice boards in the centre. Improvements were seen in the management of complaints since the last inspection of November 2023.

Regulation 14: Persons in charge

The person in charge met the criteria of Regulation 14, as they are a registered nurse with not less than 3 years' experience of nursing older persons within the last

six years. In addition, they held the appropriate management experience and qualification.

Judgment: Compliant

Regulation 15: Staffing

Inspectors were not assured that there was a sufficient number of housekeeping staff available, given the size and layout of the designated centre. Inspectors were told that management were aware of this and were in the process of seeking board approval for increased housekeeping resources.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The training matrix reviewed by inspectors outlined staff had in date training on fire safety, infection control and manual handling. However inspectors were not assured that these trainings were appropriate. As findings relating to gaps in knowledge for safeguarding and fire safety are further discussed under Regulation 8: Protection and 28: Fire Precautions.

Records showed that staff were appropriately supervised in their work.

Judgment: Substantially compliant

Regulation 21: Records

Inspectors reviewed staff files and found that some did not contain all the information as required by Schedule 2. For example, two out of four staff records reviewed did not contain a full employment history, together with a satisfactory history of any gaps in employment. One staff file did not contain a written reference from the person's most recent employer.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had failed to have effective management systems in place to ensure that all areas of the service provided was safe, appropriate, consistent and effectively monitored. This was evidenced by:

- The registered provider had no assurances that appropriate garda vetting, reference checks and training records were in place for all contracted staff.
- There was ineffective oversight of the full compliance plan from the inspection in November 2023, and therefore repeat inspection findings were found. For example:
    - The person in charge told inspectors that there was no annual review of the quality and safety of care delivered to residents completed for 2023.
    - An action plan was submitted to the Chief Inspector regarding works identified on the fire risk assessment which required the completion of actions by April 2024. On the day of the inspection, investigations were still underway on the full identification of the scope of fire safety works required. This is further discussed under Regulation 28: Fire Precautions.
    - Inspectors were not assured that management and staff received appropriate training in relation to the detection, prevention of and responses to abuse. Incidents of abuse had not been recognised and therefore not reported or investigated in line with regulatory requirements.

Judgment: Not compliant

Regulation 30: Volunteers

There was one volunteer working within the designated centre. Inspectors found that this person had their role and responsibilities outlined in writing. In addition, there was safe recruitment practices evidenced through an induction form, and a Garda Vetting disclosure.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had not submitted four notifications of safeguarding incidents within three working days of their occurrence as set out under Schedule 4 of the regulations. These notifications were subsequently submitted following the inspection.

Judgment: Not compliant

Regulation 34: Complaints procedure

Inspectors reviewed a sample of complaints recorded on the complaints log and found that complaints and concerns were promptly responded to in line with the registered provider's policy and regulatory requirements.

Judgment: Compliant

Quality and safety

The inspectors found that the residents were receiving a good standard of care that supported and encouraged them to actively enjoy a good quality of life. Inspectors observed that the staff treated residents with respect and kindness throughout the inspection and that staff were committed to providing a high quality of care to residents. However, improvements were required in some areas of quality and safety to ensure residents' safety, including safeguarding measures, the premises, infection prevention and control and fire precautions.

A selection of nursing records were reviewed on the day of inspection. Each resident had a pre assessment carried out prior to admission and a comprehensive assessment carried out within 48 hours of admission to the centre. Care plans were individualised and many clearly reflected the health and social needs of the residents.

Residents had access to a general practitioner (GP) who attended the centre regularly. The centre also had access to support from the frailty team located in the local hospital together with support from the local psychiatry of old age team. The centre had a referral system in place for health and social care practitioners, such as dietitians, speech and language therapists and tissue viability nurses, for when such services were required.

Staff training for the management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) was planned for all staff members in the coming weeks. Care plans were reflective of trigger factors for individual residents and methods of de-escalation that had a history of being effective for the resident. There was a low level of restraint use within the centre and, were it was in use, it was used in line with national policy.

On review of the complaints log it was found that an allegation of psychological abuse was not identified as a safeguarding incident and while responded to and

investigated as a complaint, it had not been investigated in line with their safeguarding policy. Furthermore, on review of the incident log a further three incidents of safeguarding concerns were identified that had not been identified or responded to as safeguarding incidents by the registered provider. This is further discussed under Regulation 8: Protection.

Inspectors found that residents' rights were promoted within Simpson's Hospital. The registered provider had employed an activitiy co-ordinator who was supported by a volunteer. There was an activity schedule on display which showed that activities were available seven days a week. A psychosocial assessment was conducted to outline residents' hobbies and interests and a record of attendance at activities was seen to be recorded documented.

Residents receiving end of life care had their needs and wishes respected and clearly documented in their care plans. There was access to medical services as required. Resident's family and friends were facilitated to remain with residents at all times, in accordance with the resident's wishes.

Overall inspectors found that the premises was kept in a good state of repair and nicely decorated. The registered provider was in the process of refurbishing the twin bedrooms. Inspectors saw that works had occurred to ensure the floor space allocated to residents measured at least 7.4m2 to include the space occupied by a bed, a chair and personal storage space, for each resident living in these twin-bedrooms. There was some outstanding maintenance works required to ensure the premises was in accordance with the statement of purpose. This is further discussed under Regulation 17: Premises.

Information was provided to residents on topics such as complaints and advocacy arrangements through a residents' guide. This guide was updated regularly and seen to reflect current and accurate information.

There was some good infection control measures in place. There was clinical hand wash facilities and sufficient amounts of hand sanitiser available on corridors. However, inspectors found that further oversight and action was required to be fully compliant with Regulation 27: Infection Control which is detailed further below.

Inspectors reviewed arrangements in place at the centre to protect residents from the risk of fire. There were contractors in the process of carrying out works to investigate and remedy containment deficiencies, however, these contractors were not on site at the time of the inspection. Immediate action was required by the provider to rectify issues relating to fire detection, means of escape, storage that was impacting on the risk of fire, and the fire risk associated with an obsolete electrical fuse panel in use in the centre. The provider responded appropriately to these risks when they were highlighted, and evidence of action taken was available before the end of the inspection. However, there were concerns raised in relation to emergency lighting, the procedures in place at the smoking shelter and extensive containment issues. These are discussed further under Regulation 28: Fire Precautions.

Inspectors reviewed the medicines and pharmaceutical services within the centre and found that the practices and systems including storage of medicines was safe.

Regulation 13: End of life

Care plans for resident's receiving end of life care were appropriate and individualised. They clearly identified the personal beliefs and wishes of the resident.

Judgment: Compliant

Regulation 17: Premises

The registered provider was required to review the floor plans to ensure that the premises was in accordance with the statement of purpose (SOP) prepared under Regulation 3. There were differences between the layout of the building and the registered floor plans. For example:

- The plant room, some storage areas, service rooms and storage space within the activity room were not indicated on plan
- There were inconsistencies in the actual location of cross corridor doors as distinct from the plans
- Some rooms were not labelled according to the plans and the SOP. For example, there was a planned upgrade of the staff changing area which were labelled as store rooms on the floor plans.

The registered provider did not, having regard to the needs of the residents at the centre, provide premises which conform to the matters set out in Schedule 6 of the regulations. For example, some areas of the premises required maintenance attention internally:

- A door to the female changing area was broken
- There was significant damage to a storage space and a toilet on the half landing of the stairs in the old section of the building.
- Inappropriate storage of building materials, maintenance equipment and paint were seen stored in basement storage spaces. The accumulation of these various items was impacting on the use of the storage space and was contrary to safe storage practice outlined in policy at the centre
- A bath was not in working order. The bath was not connected up to the water or waste supply, and it obstructed access to the "accessible" shower within the room. The shower area within this room for use by residents did not have a shower head fitted to the water feed hose

- There was no call bell or means for a resident to alert staff at the smoking shelter. The smoking shelter was visibly dirty with used cigarette butts, and rubbish bags within the hut.

Judgment: Not compliant

Regulation 20: Information for residents

The resident information guide included a summary of services and facilities, and the arrangements for visits available to residents of Simpson's Hospital.

Judgment: Compliant

Regulation 27: Infection control

There were issues fundamental to good infection prevention and control practices which required improvement. For example:

- Barriers to effective hand hygiene practice were observed during the course of this inspection. A number of clinical handwashing sinks required maintenance. For example, the taps were broken and the silicone to block the tap hole had eroded on two units.
- Despite there being a process in place for routine cleaning of curtains, a number of curtains on corridors were seen to be visibly unclean and stained during the inspection.
- Some items such as urinals and bed pans stored on drying racks in sluice rooms were unclean. This area was typically where items which had been decontaminated were stored and therefore created a cross-contamination risk.
- Inspectors were not assured that the allocated hours of cleaning were sufficient to meet the required cleaning for the designated centre. On the first day of the inspection, during the premises walk in the morning, inspectors noted the floor on corridors, in some communal areas and in store rooms was visibly unclean. Some of these areas remained unclean by 15:30pm that day. Inspectors found that given the size of the designated centre, this was an inadequate number of staff to ensure the premises was cleaned to a sufficient standard.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider was required to take immediate action on the day of inspection to rectify a number of high risk issues, which were brought to their attention. The action taken by the provider, ensured that these issues were resolved before the end of the inspection. Significant findings of non-compliance with the regulations were also identified including:

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

- The accumulation of flammable and combustible items noted within a basement storage space included high risk items such as paint and solvents. These were stored alongside combustible items such as building materials and cardboard. This room was also a plant room which had an obsolete exposed fuse board, a gas pipeline leg, which was not connected to anything, and electrical equipment associated with the hot water supply for the centre. The provider took immediate action to reduce the risk of fire within this room during the inspection.
- There was no fire extinguisher or fire blanket in place at the smoking shelter. While just one resident was a smoker, the area was clearly used for smoking activity, as there were cigarette butts, and discarded boxes in the smoking shelter.

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

- A stairwell and fire exit was partially obstructed by builders material at the start of the inspection. This was removed when identified to the provider.
- Resident seating was placed along the corridor at the nurses station. This practice required review, as it partially obstructed the escape route. In the event of an emergency, the movement of residents from this area, and the furniture placed there, would cause delays to evacuation.
- An existing entrance door and porch which was labelled as not in use, was used as a storage space for wheelchairs and other resident equipment. However, this route was identified on the floor plans posted throughout the area as a primary and secondary emergency evacuation route. This could cause significant confusion to residents staff and visitors to the centre resulting in delays to evacuation in the event of a fire.
- There was no annual certification of the emergency lighting system available to inspectors. The annual report identified failures in the emergency lighting system, which were required to be resolved before annual certification. No evidence was available that these issues had been rectified.
- An area of circulation corridor in the old section of the building, outside the visitors room did not have emergency lighting directional signage in place to identify the appropriate direction of escape in the event of a fire.
- The stairwell in the old section did not have illuminated emergency lighting directional signage in place.

The registered provider did not ensure, by means of fire safety management and fire drills at suitable intervals, that persons working in the centre and in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of a fire. For example:

- While there were extensive fire drills completed at the centre, some high risk scenarios were not being trialled fully. For example, the largest compartment of 13 residents, did not have a complete evacuation complete. The compartment evacuation completed in this area only evacuated five rooms, and six residents. This meant that inspectors could not be assured that all residents could be evacuated in a timely manner in the event of a fire.
- There was no mention of closing doors as part of the evacuation procedure trials. There were no bedroom door closers fitted within the centre, which meant that the manual closing of doors was an important step in the containment of fire smoke and fumes in the event of a fire. Furthermore, it was noted throughout the inspection that practice at the centre was to leave bedroom doors open when there was nobody in the rooms. This required review, as the containment of fire would be compromised in the absence of automatic closing devices to the doors.
- Inspectors could not be assured that the disabled refuge space within the stairwell of the upper ground floor was effective for the needs of residents in adjoining compartments that might require this space. The layout of the area meant that the space was limited in size. This could impact on horizontal evacuation which is relied upon for evacuation in the event of a fire.

The registered provider did not make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including the procedures to be followed should the clothes of a resident catch fire. For example:

- There was no smoking apron, or fire fighting equipment available at the smoking shelter. One resident at the centre was a smoker, and was observed smoking in a location which was not a smoking area designated by the provider. This could impact on the resident as the procedure for smoking clearly indicated that the smoking shed was the only location for use while smoking due to the high risk of fire associated with it.

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

- While work was being done at the centre to address some containment issues, additional containment concerns were identified on this inspection including:
    - Containment measures were not sufficient above doors within electrical and mechanical service rooms. This would impact on containment of fire, smoke and fumes in bedroom areas, and would impact on the relative safety of adjoining compartments in the event of a fire.

- Containment measures were not in place in the under stairs storage space on the lower ground floor. This area was used to store wheelchairs and mobility equipment. The lack of containment measures in this space would impact on the escape stairs route from the floor above.
- An electrical riser which shared a wall with a store room on the corridor of the resident area of the upper ground floor did appear to not have adequate containment measures in place. There were service penetrations through the wall, and the wall itself did not appear to be a fire rated wall.
- Fire doors in the centre were noted with large gapping around the perimeter. This would impact on their ability to contain fire and smoke in the event of a fire.

- Fire doors to some areas were noted as being held open with wedges including a dry goods store in the basement and a basement store room. Resident bedrooms were also noted as being left open while the residents were elsewhere in the centre.
- Containment measures did not appear to be in place around some electrical risers and distribution boxes in the basement. A plant room which included an electrical fuse board with obsolete screw in fuses, did not have a fire door fitted to it.
- A blue plastic shoe cover was fitted over a smoke detector in a stairwell. This would prevent the device from detecting smoke in the area and would delay the activation of the fire alarm in the event of a fire.
- A storage cupboard within the corridor in the old section of the centre did not have fire detection as required to comply with the requirements of the centres fire detection system which was a category L1 system.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

There was an appropriate pharmacy service offered to residents and a safe system of medication administration in place. Policies were in place for the safe disposal of expired or no longer required medications.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Care plans were individualised and reflective of the health and social care needs of the resident. They were updated quarterly and sooner if required. Care plans demonstrated consultation with the residents and where appropriate their family.

Judgment: Compliant

Regulation 6: Health care

The registered provider had ensured that all residents had access to appropriate medical and health care, including a general practitioner (GP), physiotherapy, speech and language therapy and dietetic services.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The person in charge had planned training to ensure that all staff had up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

There was a low level of restraint in use in the centre and restraint was only used in accordance with national policy.

Judgment: Compliant

Regulation 8: Protection

While staff had access to safeguarding training, this training was not effective. Inspectors found that four safeguarding incidents had not been recognised and responded to in line with the registered providers safeguarding policy. This failure to recognise safeguarding concerns creates a significant risk for residents.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents were consulted and had opportunities to participate in the organisation of the designated centre through monthly residents' meetings and through surveys.

Inspectors saw that poor feedback relating to the laundry service was being responded to.
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 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: End of life	Compliant
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Simpson's Hospital OSV-0000096

Inspection ID: MON-0042493

Date of inspection: 16/05/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: - Additional staffing approved by Trustees and an extra housekeeping staff member is going to commence from 01/07/24 totalling upto 3 housekeeping staff for 5 days and extra hours on the weekends.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: - Simpson's Hospital in- house trainer has completed a refresher training course on safeguarding older adults in June 2024 and commenced training new and existing staff in simpson's hospital. - Tool box talks have commenced on fire safety precautions. - Increased supervision on the floor by CNM to ensure the training principles are applied by staff. - Regular and constant monitoring of all staff.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records:	

- An audit of staff personnel files has been completed.
- An action plan is in place to close any issues identified in the audit.
- Recruitment policy will be updated by 31/07/2024.
-Commenced with all new starters having the Garda vetting completed along with 2 recent references and gaps in the CV explained before joining Simpson's Hospital.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
- Simpson's Hospital received Service Level Agreement from external contractors to ensure safe recruitment practices are being upheld.
- Staff files for sub-contracted employees are held on the premises.
- A copy of Garda vetting and training records will be held on- site for all housekeeping staff.
- The PIC started in February 2024 and will complete the annual review for 2024 when required.
- Going forward, Chief Inspector will be notified if there are any delays in the designated works submitted to be completed within the specified time frame.
- PIC will identify all incident and complaints, if required an investigation will be carried out. The Chief Inspector will be notified if the incident or complaint is being identified as a notifiable incident.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
- PIC will review incidents, complaints and if the incidents are notifiable, they will be notified to Chief inspector within the specified time frame.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

- An Architect has been engaged and floor plans are being reviewed, this will be completed by 31/07/2024.
- Storage space and toilet on the half- landing of the stairs will be repaired by the end of 30/09/2024. The storage room has been cleared and is not in use.
- Works scheduled to clear the basement storage spaces and to use safely by 30/09/2024.
- A shower head is fitted to the water feed hose in the assisted bathroom on Upper Ground Floor
- All resident equipment has been removed from the porch.
- Awaiting a spare part for bath to be repaired, an external company has been engaged for the works.
- A call bell has been sourced and will be installed in the smoking shelter by 31/07/2024.
- Smoking shelter cleaned and a cleaning schedule commenced for smoking shelter.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
- Clinical handwash sinks are scheduled for maintenance and works will complete by 30/09/2024.
- All privacy curtains on corridors have been taken down.
- IPC link practitioner commenced an education programme for all staff in regards to cross contamination.
- PIC/CNM commenced auditing the sluice rooms to ensure that there is no cross-contamination risk.
- Cleaning hours reviewed and additional staffing is going to commence from 1st July 2024.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
- Work on the containment measures has commenced. Much work has been completed regarding compartmentation, which is ongoing. This includes creating fire-resisting compartments to contain fire and smoke, providing additional time for safe evacuation. Our ongoing efforts in this area will further enhance the safety of all occupants. The works are to be completed by the end of August 2024.
- Fire door risk assessment is completed on 17th June 2024. Works arising from the report will be aimed to be completed by 31/08/2024.
- Kitchen staff have been instructed not to wedge fire doors. Compliance with this

instruction is being monitored daily by hospital management.
- Obsolete fuse board was replaced on the 17th May 2024. Our commitment to safety is ongoing, as evidenced by our current electrical safety works. These works underscore the need for continued vigilance and adherence to safety protocols and involve regular inspections and maintenance to ensure all electrical systems are safe and compliant with current safety standards.
- Fire detection will be installed in the cupboard. To be completed by the end of August 2024. We can confirm the successful completion of the fire detection and alarm system upgrade in October 2023. This upgrade, which is compliant with IS 3218 standards, ensures reliable early detection and warning in case of a fire. Regular maintenance and testing are scheduled to maintain its optimal performance, demonstrating our proactive approach to safety.
- During our fire safety training courses, staff are instructed to close doors after evacuating each room. This instruction is also on the staff action signs displayed throughout the building. This practice is crucial in limiting the spread of fire and smoke, thereby enhancing the overall safety of the premises during an evacuation.
- Tool box talks have commenced informing staff to close bedroom doors, this is monitored by hospital management and the nurse in charge.
- The closing of doors is included in the evacuation procedure and fire drills
- Procedures are in place to ensure any smoke detector that has to be covered to allow works take place is removed as soon as works are completed.
- A fire extinguisher has been installed at the external smoking area. In our fire safety training, techniques to deal with clothing fires are thoroughly covered. This includes the correct use of fire extinguishers and the importance of smothering flames safely. The training is third-party certified, ensuring our staff receive high-quality, reliable instruction.
- Regarding the provision of extinguishers in the smoking area, it is emphasised that the resident who smokes is independent and can leave the centre to go uptown; thus, they are not at significant risk as they can smoke independently outside the centre. However, resident will be reminded to use the designated smoking area. A Portable fire extinguisher is in place as recommended.
- Fire consultant have been engaged to review directional emergency lighting in Simpson's Hospital. The works arising from the review will be aimed to complete by 30/09/2024.
- Annual Emergency Lighting Certificate has been issued on 18th June 2024.
- Resident seating at the nurse's station has been reduced to ensure circulation is not obstructed.
- Our staff play a crucial role in our fire safety measures. We have implemented comprehensive fire safety training programs to ensure all staff are proficient in fire prevention, emergency procedures, and the correct usage of firefighting equipment. Training includes theoretical instruction and practical exercises tailored to the needs of our nursing home environment. According to the guidelines from our fire consultant, our training covers evacuation procedures, understanding fire alarm systems, use of extinguishers, and techniques to address clothing fires. The course is certified and delivered by experienced trainers, ensuring our staff are fully equipped to handle fire-related emergencies confidently and competently.
- Monthly evacuation drills are commenced by PIC/CNM with staff in Simpson's. The first evacuation drill started with the largest compartment of 13 residents on 3/07/2024. The same will continue with all compartments in Simpson's hospital.

Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: - Safeguarding training for the trainer has been updated in June 2024. - Refresher training commenced for clinical staff on 17th June 2024 and will complete by 30/09/2024. - PIC commenced on submitting notifications to chief inspector within the time frame and responding in line with the centre's safeguarding policy by linking with HSE safeguarding and protection team. - Incidents and complaints will be monitored by the PIC. - Tool box talks commenced in handovers to all staff.	

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	01/07/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/09/2024
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of	Not Compliant	Orange	30/09/2024

	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	30/09/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	30/07/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/09/2024
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with	Not Compliant	Orange	01/03/2025

	relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	30/09/2024
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	30/09/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/09/2024
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre	Not Compliant	Orange	30/09/2024

	to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	30/09/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/09/2024
Regulation 31(1)	Where an incident set out in paragraphs 7 (1)	Not Compliant	Orange	01/06/2024

	(a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	30/09/2024
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Not Compliant	Orange	30/09/2024