Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

Centre name:	Queen of Peace Nursing Home
Centre ID:	0379
Centre Address:	Claremorris Road
	Knock
	Co. Mayo
Telephone number:	0949-388279
Fax number:	0949-388859
Email address:	queenofpeacecare@gmail.com
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	MMM Partnership
Person in charge:	Fidelma Mohidin
Date of inspection:	11 and 12 January 2011
Time inspection took place:	**Day 1: Start:** 09:30 hrs **Completion:** 17 :30 hrs **Day 2: Start** 09:30 hrs **Completion :** 16:00 hrs
Lead inspector:	Mary Mc Cann
Support inspector(s):	PJ Wynne
Type of inspection:	☒ **Registration** ☐ **Scheduled** ☒ **Announced** ☐ **Unannounced**

About inspection

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

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

1. Governance and leadership: how well the centre is organised.
2. The quality of the service.
3. How well the healthcare needs of residents are met.
4. Premises and equipment: appropriateness and adequacy.
5. Communication: information provided to residents, relatives and staff.
6. Staffing: the recruitment, supervision and competence of staff.

This report summarises the findings of the inspection under some or all of these topics, highlighting areas of good practice as well as areas where improvements were required as follows:

Evidence of good practice – this means that an acceptable standard was reached and the provider demonstrated a culture of review and improvement and aimed to drive forward best practice.

Some improvements required – this means that practice was generally satisfactory but there were areas that need attention.

Significant improvements required – this means that unacceptable practice was found.

The report also identifies minor issues, where applicable, to which the provider should give consideration to enhance the quality of the service.

Registration inspections are one element of a process to assess whether providers are fit and legally permitted to provide a service. The registration of a designated centre is for three years. After that the provider must make an application for registration renewal at least six months before the expiration date of the current registration. New providers must make an application for first time registration 6 months prior to the time the provider wishes to commence.
In controlling entry to service provision, the Chief Inspector of Social Services is fulfilling an important regulatory duty under section 40 of the Health Act 2007. Part of this duty is

a statutory discretion to refuse registration if the Chief Inspector is not satisfied about a provider's fitness to provide services, or the fitness of any other person involved in the management of a centre.

The registration inspection is one element for the Chief Inspector to consider in making a proposal to the provider in respect of registration. Other elements of the process designed to assess the provider's fitness include the information provided in the application to register, the Fit Person self-assessment and the Fit Person interviews. Together these elements are used to assess the provider's understanding of, and capacity to, comply with the requirements of the regulations and the Standards. Following assessment of these elements, a recommendation will be made to the Chief Inspector and the formal legal process for registration will proceed. As a result, this report does not outline a final decision in respect of registration.

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

About the centre

Description of services and premises

Queen of Peace Nursing Home was established in 1990.The centre accommodates up to 37 residents and offers long term, respite and convalescent care. Although currently registered for 37 residents the provider has decided to limit bed occupancy to 32 residents in order to ensure greater privacy and space for residents. It caters for residents who mainly have physical problems as a result of ageing and people with cognitive impairment and/or dementia.

The centre is single-storey in bungalow style. All accommodation is on the ground floor. Residents have the choice of either private or semi-private bedrooms. There are 19 single and four twin bedroom with en suite toilet and wash-hand basin facilities, one additional single room and two twin rooms.

Communal accommodation consists of a dining area adjacent to the kitchen, two sitting rooms, a smoking room/visitors' room and a chapel. A further five toilets and two assisted bathrooms and three showers are available. Offices, storage space and a sluice room complete the layout. There is a garden to the side and ample car parking is available to the front of the building.

Location

The centre is located on the Claremorris Road, a few minutes drive from the Knock Shrine Basicilla. It is close to shops and business services in Knock village.

Date centre was first established:	1990
Number of residents on the date of inspection	29
Number of vacancies on the date of inspection	3 (although registered for 37, the providers have limited their total to 32)

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	1	9	11	8

Management structure

The providers are MMM Partnership. Raffick Mohidin is the designated provider on behalf of the partnership. His wife Fidelma Mohidin is the current Person in Charge as Diane Angel Cosgrove, who is the appointed Person in Charge, is on long term leave. A team of staff nurses, carers, catering and housekeeping staff support the person in charge.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	1	4	1	1	0	2*

*provider and maintenance staff

Summary of findings from this inspection

This was an announced registration inspection and the third inspection by the Health Information and Quality Authority (the Authority). This inspection took place over two days. A scheduled unannounced inspection had previously been carried out by the Authority, Social Services Inspectorate on the 25 November 2009. An action plan detailing areas which required attention was forwarded to the provider post this inspection. A follow up inspection was undertaken on the 28 June 2010. Post this inspection, an action plan was sent to the designated provider and person in charge detailing areas which required review. As part of the registration inspection these actions were also reviewed by the inspectors.

In order to gain registration the provider has to satisfy the Chief Inspector that he/she is a fit person and will comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended), and show a willingness to comply with the Authority's standards. The person in charge confirmed to inspectors that the fit person self assessment document had been completed jointly by the provider and herself.

Documents reviewed by inspectors prior to the inspection included the fit person self assessment document, a pre-inspection questionnaire (which had been completed by the provider), the statement of purpose for the centre, resident and relative questionnaires and notifications of serious incidents. Other documents reviewed during and post-inspection included residents' care plans, accident and incident records, the residents' guide, the record of complaints, staff duty rotas, policies, procedures and staff training records. Inspectors spoke with residents, relatives and staff during the inspection and observed care practices and the quality of the environment.

Inspectors carried out separate fit person interviews with the designated provider and the person in charge. Inspectors also interviewed the staff nurse who primarily deputises for the person in charge in her absence. Staff interviewed for the purposes of fitness were knowledgeable of and committed to meeting 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.* They demonstrated a working knowledge of the relevant legislation and standards.

Several improvements had been made since completion of the fit person self-assessment document such as reviewing the statement of purpose and the residents' guide, staff training in the area of dementia and challenging behaviour, review and revision of the activity schedule and upgrading the premises.

Inspectors found the centre to be adequately managed and were satisfied with the standard of medical and nursing care provided. All policies and procedures required by current legislation were in place. Residents and relatives were complimentary of the staff and positive in their comments regarding the care provided.

The Action Plan at the end of this report identifies areas where improvements are needed to meet 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 improvements included for example involvement of residents and relatives in care planning and development of audit and review of service provision.

Comments by residents and relatives

Inspectors received five completed questionnaires from residents and six from relatives/carers. These contained positive comments and were complimentary of the service provided. Inspectors also met with residents and relatives during the inspection. They were also complimentary of the service provided and felt that the centre was "well run", and the care delivered to their loved ones was of a high standard.

Residents and relatives could clearly identify the person in charge. They were positive in their comments in relation to her commitment to providing a quality service. They described her as "kind" and "a caring person". They said she was "approachable" and they could talk to her if they had a problem. They confirmed that she was in the centre on a daily basis. "We see her nearly every day". Some residents were unable to verbally express their views due to communication difficulties and confusion associated with dementia.

Residents and relatives were of the view that there was adequate staff on-duty to meet the needs of the residents. Relatives said that staff were readily available to talk to them.

Residents spoken with stated that they felt safe in the centre. They stated that they "enjoyed the activities" for them to partake in during the day. Many commented positively on the religious component to the activity programme. Some residents stated that the location of the centre so near to Knock Shrine was a factor in choosing this centre. They also confirmed that they read the daily newspaper, which was provided.

Overall findings

1. Governance: how well the centre is organised

Outcome: The centre is well organised and managed and complies with the requirements of the Health Act 2007, the regulations and standards.

Good governance involves the effective and efficient deployment of resources in accordance with the stated purpose and function of the centre. Governance includes setting clear direction for the service, a commitment to continual improvement and having a system in place to effectively assess and manage risk.

Evidence of good practice

A clear organisational structure was in place and the provider was actively involved in the day-to-day operation of the centre, providing ongoing support to the person in charge. Staff interviewed were knowledgeable about their roles and responsibilities. They were able to describe the staff structure and the reporting mechanisms in place to ensure appropriate delegation, supervision and competence in the delivery of care to residents. They confirmed that the provider and person in charge were easily accessible and onsite daily at the centre. They commented on this being positive and stated that both were supportive of staff.

The inspectors reviewed the directory of residents which was up to date. It detailed when a person was transferred to hospital and the reason for transfer. It contained all other information required by the regulations.

Valid insurance cover was in place and each resident had a written contract of care. This detailed the terms and conditions of the occupancy including services provided and fees to be charged. The cost of services not included in the fee such as hair dressing was identified.

While a complaints log was available in the centre no complaints had been documented. The provider and person in charge confirmed that they had received no complaints and where residents made suggestions for change they acted upon these swiftly. The person in charge described an example of this. She stated that the residents stated they liked the Sonas session which occurred once weekly, so this now occurs twice weekly. The provider was clear of the necessity of a transparent easily accessible complaints procedure. Residents spoken with displayed an awareness of their right to voice any complaint that they wished. They told inspectors that they would talk to the person in charge or the provider or the nurses if they had a complaint. All residents spoken with confirmed that they were satisfied with the service provided and had no complaints at the current time.

A comprehensive plan was in place to manage risks. The plan identified clinical and environmental hazards and controls to minimise these risks. The provider and person in charge confirmed that they were constantly reviewing risks and hazards on a day to day basis.

Hand gels, gloves and aprons were available throughout the centre and inspectors observed staff using these. The Authority had received notifications of accidents and/or serious incidents and quarterly returns from the centre. These were up to date at the time of inspection.

A missing person's policy was in place which included clear procedures to guide staff should a resident go missing. Photographic identification was available for each resident. A description sheet was not available which would assist emergency services should a resident go missing. The person in charge confirmed that missing persons drills were carried out on a regular basis. A signing in register was available on entering the centre. This allowed the person in charge to monitor the movement of persons in and out of the building to ensure the safety and security of residents.

The provider was an agent to manage pensions on behalf of some residents. A separate file was available for each resident, which clearly documented the financial transactions. Where the resident had capacity, their signature was documented and where they were incapacitated, the signature of the resident's significant other was available. One resident had some cash in the centre's safe. She had requested that this remain onsite. The provider had discussed this with her next of kin who agreed with the resident. An individual file was available for each resident detailing their finances and a statement was made available to the residents every three months.

All policies required by the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) were in place. The person in charge stated that she planned to introduce polices in stages and would provide training for staff to ensure their understanding of all policies and procedures.

Mail was observed to be hand delivered unopened by staff to residents. Residents informed the inspectors that staff assisted them when requested to do so.

Some improvements required

A major emergency plan was in place to guide and assist staff in responding to untoward incidents. This detailed a clear procedure to follow in the event of utility failure, flooding and missing persons. However, a designated place of safety was not identified in the plan should it be deemed necessary to evacuate the building.

The centre had a statement of purpose available. The residents' guide and statement of purpose were contained in the same document. It set out the objectives and philosophy of the service to be provided. The person in charge informed the inspector that a copy of the statement of purpose was made available to each resident. Admissions are not made to the centre until an assessment of their needs has been undertaken by the centre. This assessment involves the individual, their family or significant other and phone contact with any professionals involved in their care. Although, the statement of purpose had been recently updated, it requires significant revision to comply with current legislation. It did not detail for example, the staff allocation or whether the centre would accommodate emergency admissions. It also failed to address the age range of residents the centre wished to accommodate.

A petty cash system was in place to manage small amounts of money for some residents. A record of the handling of money was maintained for each transaction. One signature was recorded where petty cash was received from relatives. This was discussed with the provider who stated he would immediately ensure that two signatures were available for all transactions. The individual balance was clearly available for each resident.

Significant improvements required

There were arrangements in place for recording and investigating untoward incidents and accidents. A description of the accident was recorded. There was no evidence by way of a signature, for example to indicate that they had been reviewed by the person in charge. No detail was made on the accident form or in the case notes of any preventative measures to reduce the likelihood of reoccurrence. There was poor evidence available that residents who had an accident were seen by their general practitioner (GP), by the on-call service or taken to the local hospital, or whether consideration was given to this option, but a decision made that it was not necessary in the circumstances. Where a resident sustained a fall unwitnessed by staff or when observed to hit their head on falling, neurological observations were not recorded to determine if a head injury had been sustained and/or the level of consciousness affected.

The provider demonstrated a commitment to provide a quality safe service. However, a system for the review of the quality of care and the quality of life of residents was not in place. There was no auditing or analysis of information to guide quality improvements. Areas such as medication errors or near misses, accident and incidents, care plans or restraint practices had not been audited to enhance outcomes for residents.

While an individual record of each resident's personal property was recorded on admission, this was not updated to reflect changes throughout the residents stay. Inspectors confirmed with residents that there were no instances of missing items.

2. Quality of the service

Outcome: Residents receive a good standard of service, appropriate treatment and are treated with courtesy and respect.

A quality service is one where residents are protected from harm or abuse, where practice is person-centred, where rights are protected, where residents are enabled to play an active part in the centre and where management, staff and residents work together towards continuous improvement.

Evidence of good practice

The person in charge informed inspectors that one staff member is always available in the sitting room area. On the day of inspection, inspectors observed that there was a staff member on all occasions in the sitting area.

A new call bell system was in place. Call bells were available at each resident's bed and all residents were familiar with and the bell was accessible from the bed and a chair by the bed. A call bell was also available in all toilets. Residents confirmed that staff responded to call bells in a timely fashion, "can ring bell at any time and they will come and answer".

Residents' privacy and dignity were respected by staff. Inspectors observed staff knocking on bedroom, toilet and bathroom doors and waiting for permission to enter. Residents were smartly dressed and their clothes looked well cared for. A resident told inspectors that they could choose what clothes they wished to wear. Inspectors observed staff interacting with residents in a courteous manner.

Staff provided residents with choice in many aspects of their lives. Residents told inspectors that they could decide how to spend their day. Some residents said they chose to read the paper in the 'quieter' sitting room after breakfast. Residents told inspectors that they liked to spend time in their own room and staff respected their wishes.

Inspectors observed that the dining experience was a social and interactive occasion. All residents were asked for their preferences earlier in the day. A menu was available in the dining room. Staff were observed assisting residents discreetly and respectfully if required. The meal was well presented and residents confirmed that they enjoyed the food. Details of residents likes/dislikes and preferences are recorded by kitchen staff along with any special dietary requirements.

Inspectors saw residents being offered a variety of snacks and drinks. Jugs of squash and water were available in common areas and individual bedrooms and staff regularly offered drinks to residents. Residents informed the inspectors that snacks were available during the night and staff confirmed they had access to the kitchen 24 hrs a day.

Residents had a daily programme of meaningful and appropriate activities. This was an area where considerable developments had taken place. Activities available to enhance meaningful occupation for residents included music and dancing, card games, Sonas,

Mass, prayers and visits to Knock shrine. On the day of inspection it was noted by the inspectors that a variety of activities were available to residents. The person in charge informed the inspectors that she is always looking into new methods which may be of interest to the residents. They have commissioned a Sonas therapist to provide Sonas sessions as they tried this out and received positive feedback from the residents. Sessions now take place twice weekly. One resident who has an interest in gardening had been assisted by staff to tend her own plot in the internal courtyard area.

Residents' civil and religious rights were respected. Arrangements were in place for residents to vote if they so wished. Mass was celebrated in the centre on a weekly basis and in addition, there was a prayer service and Holy Communion every day. Details of ministers from all denominations were available if required. The Legion of Mary visits the centre every two to three weeks.

There was a policy for end-of-life care which provided direction to staff on the care of residents who were dying. Case files reviewed contained individual end of life care wishes.

Significant improvements required

Restraint measures were in place. While the use of bedrails and tilt type chairs had decreased from previous inspections, they were still in use. Some documentation was in place in relation to the restraint measures. However, no valid informed consent was recorded. Care pans were in place documenting the rationale for the use of the restraint measure but evidence was not available that this was the least restrictive option to ensure the safety and welfare of the resident. Records in relation to the ongoing review of restraint practices were of poor quality. There were no records available documenting motion times during waking hours when the resident was not subject to the restraint measure to ensure compliance with good practice guidelines. There was no policy or procedural guidelines available to staff to guide and inform them on the use of restraint.

There was no evidence of a formal review of the quality and safety of care provided to residents. No evidence of any audits or review of care given was available.

Minor issues to be addressed

While progress had been made in the area of activities, there were no life histories completed for residents in the centre. Completion of these documents would enhance the person-centred approach to activities and ensure that specialist personal interests were linked into the programme of activities.

3. Healthcare needs

Outcome: Residents' healthcare needs are met.

Healthcare is integral to meeting individual's needs. It requires that residents' health, personal and social care needs are assessed and reviewed on an ongoing basis, within a care planning process, that is person centred. Emphasis is firmly placed on health promotion, independence and meaningful activity.

Evidence of good practice

Inspectors were informed by staff that there were good communication links with the supplying pharmacy. A pharmacist attended the centre in September 2010 and spoke with nursing staff in relation to safe administration of medication. The inspectors checked the controlled drug stock and spoke with staff in relation to safe practice, handling, storage and administration of controlled drugs and found that this complied with good practice guidelines.

A nutritional assessment was completed on all residents on admission. All residents were weighed monthly and a record was available of this on files reviewed. Fresh fruit and vegetables were observed to be available.

Residents were enabled to retain the services of the own general practitioner (GP) or alternatively were offered the services of the centre's GP. The sample of medical records reviewed confirmed that the health needs of residents were being monitored on an ongoing basis and no less frequently than at three monthly intervals. All residents had received the flu vaccine. Satisfactory medical out-of-hours arrangements were in place through out-of-hours medical services. From review of the case files, the inspectors observed good recording of the clinical status of the residents. Residents who had dementia and or challenging behaviour had access to the psychiatry of later life services to provide specialist advice and guidance.

Safe practice was observed in medication administration. Medication was administered from blister packs. Nursing staff administering medication were knowledgeable of the medication they were administering and the reasons for its administration. Photographic identification was in place on medication administration charts.

Access was available to palliative care, dental and optician services. The chiropodist attended the service every six weeks while physiotherapy and occupational therapy were also available.

There was good evidence of infection control measures in place. Hand sanitizers were strategically placed throughout the centre and staff had received training on infection control measures. Good evidence of hand-washing was observed.

Some improvements required

All residents had a care plan. A sample of care plans were reviewed by the inspectors. Some had been reviewed within the previous three months but this was not consistent on all files. Where care plans had been reviewed, there was no narrative in the case files detailing the review. The only evidence available was a staff signature to say they were reviewed. In relation to consultation with the resident or significant other, no evidence was documented that staff had consulted with residents in relation to their care plan and residents' views were not documented in the care records. Furthermore, residents consulted were unaware they had a care plan. No audit of care plans had been carried out.

The medication policy did not include the procedure to follow in the case of medication error.

The person in charge stated that the centre did not have access to wound care specialist services. There were no pressure sores at the time of inspection. However, the inspectors discussed with the provider the need to make arrangements for access to wound specialist input should the need arise.

Significant improvements required

The medication was administered from blister packs. A small percentage of charts did not have the time of administration recorded by the prescribing doctor. Staff dispensing the medication was relying on the pharmacy dispensing sheets for dispensing and signing these off on administration. These sheets had the time of administration recorded. Inspectors were informed that the original prescription was at the pharmacy. The pharmacy dispensing sheets were returned with the blister packs. Discontinuation of medications was not clear. The medical staff had not signed or stated a date of discontinuation. PRN (as required) medication and regular medication were charted together which could increase the likelihood of an error in administration. Practices were not in line with An Bord Altranais.

4. Premises and equipment: appropriateness and adequacy

Outcome: The residential care setting provides premises and equipment that are safe, secure and suitable.

A good physical environment is one that enhances the quality of life for residents and is a pleasant place to live. It meets residents' individual and collective needs in a comfortable and homely way, and is accessible, safe, clean and well-maintained. Equipment is provided in response to the assessed needs of each of the residents and maintained appropriately.

Evidence of good practice

The centre was purpose-built, with a good standard of private and communal space and facilities. The providers had made many improvements to the environment since the last inspection and informed the inspectors that they plan to continue to upgrade the environment. The environment was bright, clean and tidy throughout and had appropriate pictures and furnishings. Residents reported that the centre offered a lovely comfortable environment and told inspectors that they enjoyed the lifestyle provided. The location near Knock Shrine was a feature that many residents said helped them in their faith and they were very pleased to be able to live so near the shrine. Some recounted stories of how important this was for them and how much comfort they gained from this. The windows are low and provided good visibility for residents. Some residents stated the y enjoyed watching people "coming and going".

Residents' bedrooms were comfortable and personalised. There was adequate privacy in shared rooms, privacy curtains were observed to close properly. Residents interviewed said that they were happy with the accommodation provided and that they were encouraged to personalise their rooms with individual possessions.

The kitchen was found to be clean and well-organised. Catering staff interviewed had received food handling training and were knowledgeable about residents' dietary needs.

There was a patio/garden area to the side of the building. A gardening plot was observed by the inspectors where a resident who enjoyed gardening had been facilitated by the centre to continue with their hobby.

Toilet facilities were provided beside day areas and throughout the building for residents' convenience. Showers and toilets were provided with grab support rails. An oratory was available for residents use. There was sufficient number of toilets, showers and baths provided to meet the needs of the residents. Shower and bathroom areas were maintained in a clean condition. Handrails were provided along the corridors throughout the building, thereby promoting residents independence. Hand testing indicated the temperature of radiators and the hot water did not pose a burn or scald risk to residents.

The fire policy and procedures were viewed by the inspectors and found to be centre-specific. Records were available supporting that all staff had attended fire safety and prevention training.

The fire alarms, extinguishers, hoses, blankets and emergency lighting were checked and serviced by external companies. This was last completed in May 2010. The records inspected indicated that they had been maintained in accordance with legislation and best practice. Staff interviewed were aware of how to respond in the event of fire. All fire exits were checked on the day of inspection and found to be unobstructed. Smoke detectors and heat detectors were located in all bedrooms and general purpose areas. Emergency lighting was provided in all areas throughout the building. All fire exits were checked by the inspector and were found to be unobstructed on the day of inspection.

Hoists and other equipment had been maintained and service records were up-to-date. These were last serviced in May 2010. Appropriate assistive equipment such as hoists, pressure relieving mattresses, cushions, wheelchairs and walking frames were available.

A bedpan washer has been installed in the sluice room. Shelving and storage space was also available. The waste management system was well-managed and secure. A contract for the removal of waste was in place.

The centre had access to maintenance personnel who responded to all the day-to-day maintenance demands. The fire alarms, extinguishers, hoses, blankets and emergency lighting were checked and serviced by external companies.

Routine fire drills occurred. Records were available to support that the last fire drill was held in October 2010. These reinforced the theoretical training provided, to ensure staff were confident of the procedure to be followed in the case of a fire.

Some improvements required

Directional signage, appropriate fire procedures and exit directions were not displayed throughout the building.

There were no staff changing facilities except for a toilet for catering staff. The person in charge informed the inspectors that planning had been approved for a 22-bedded extension which would include staff changing facilities.

Significant improvements required

Individual risk assessments detailing evacuation procedure to be adapted in the case of fire were not available for each resident.

The mop cleaning system in place did not comply with best practices. Cleaning equipment including the cleaning trolley was stored in the sluice room as no cleaning room was available.

Minor issues to be addressed

The smoking room is functioning as a dual purpose smoking/visitors' room. A ventilation fan was in situ. A designated visitors' room is included in the plans of the new extension.

The person in charge informed the inspector that he had requested that the local fire officers attend the centre to carry out a familiarisation visit but this had not occurred to date.

5. Communication: information provided to residents, relatives and staff

Outcome: Information is relevant, clear and up to date for residents.

Information is accessible, accurate, and appropriate to residents' and staff needs. Feedback is actively sought from residents and relatives and this informs future planning and service provision. Information is recorded and maintained in accordance with legal requirements and best practice and is communicated to staff on a need to know basis to ensure residents' privacy is respected.

Evidence of good practice

Daily national and weekly local newspapers were available. A cordless phone was available to facilitate resident's privacy taking phone calls. Some residents also had personal mobile phones. A notice board detailing the day date and activities was available in the dining room. Residents stated that they could talk to staff at any time.

The day-to-day involvement of the provider and the person in charge supported direct verbal communication between residents, staff and visitors. The inspectors were told by residents that both the provider and the person in charge were always available and they felt that communication was welcomed and encouraged. Relatives were satisfied with information provided by staff about residents' healthcare and general wellbeing. Relatives confirmed in person and on the completed questionnaires that staff communicated regularly with them and they were kept updated in relation to the care of their relative.

The person in charge directly supervised and worked with staff. Inspectors observed that the person in charge had good interpersonal and social skills when interacting with residents and staff. Daily staff handover meetings which informed the incoming staff group of the health and wellbeing of the residents took place at the change of each shift. Inspectors noted that residents and staff files were maintained confidentially. Records required by the legislation were stored securely and accessible when requested.

A communication policy was in place and there was evidence of good communication links between nursing and catering staff. Communication links throughout the centre were good, ensuring continuity of care. A nurses' communication detailing daily issues and resident appointments was used by staff to promote communication.

Some improvements required

Inspectors observed that some residents had communication difficulties due to dementia or cognitive impairment. Inspectors found the building lacked orientation cues for residents with dementia. For example, bedrooms and bathrooms were not easily identifiable from the corridor. All doors were painted the same colour and there were no pictures and or appropriate signage on doors to assist resident's orientation to their environment. The provider and person in charge informed the inspectors that they had

enlisted the assistance of a Sonas therapist and she was providing two sessions per week with a specific focus on dementia residents. They were of the view that this was a means of enabling residents who were unable to communicate an alternative means of communication.

There was a comprehensive set of operating policies available. However some staff spoke with were unaware of the contents or existence of specific policies.

Minor issues to be addressed

While there was an elder abuse and protection policy in place, this did not include the details of the local dedicated abuse officer.

The person in charge stated that three monthly staff meetings were held. Minutes of these were available. Minutes of meetings to date revealed that these are used for introduction and training on policies

While there was evidence that the provider and person in charge were accessible to the residents and responded to feedback and suggestions from the residents, there was no residents' committee in place. The provider informed the inspectors that he had tried to set one up but it had not been successful. He gave a commitment to continuing to try and set up same.

While each staff grade wore a different coloured uniform, not all staff wore name badges.

The residents did not have access to independent advocate/advocacy service. The provider informed the inspectors that the centre would have an independent advocate in the near future. An individual has been identified and she is currently undertaking training in this area and as soon as this is complete, she has given a commitment to provide advocacy services at the centre.

The residents' guide and statement of purpose are both contained in the same document. It is recommended that these are separate.

6. Staff: the recruitment, supervision and competence of staff

Outcome: Staff are competent and recruited in sufficient numbers to meet residents' needs

Staff numbers and skill-mix are determined by the size and complexity of the service and there should be sufficient competent staff on duty, both day and night, to meet the needs of residents. Robust recruitment and selection procedures ensure the appointment of suitably qualified and experienced staff. Staff are supported in their work by ongoing training and supervision.

Evidence of good practice

The inspector viewed the staff rota and found that the planned staff rota matched the staffing levels on duty. The staff roster detailed their position and full name. A registered nurse was on duty at all times. When the person in charge was on duty there usually was another staff nurse on duty thereby enabling her sufficient time for management and governance tasks and to support and supervise staff. There was a system in place to provide cover in the absence of the person in charge. An experienced staff nurse deputised for her in her absence. This staff nurse often worked with the person in charge and told inspectors she felt confident in providing cover when required. There was an on call system in place to access the provider and person in charge which staff were aware of.

Currently the centre has 17 care assistants, of which nine have Further Education and Training Awards Council level five training or equivalent in the care of older people. One care assistant has a degree in Applied Social Studies in Social Care takes lead in developing the activities schedule. A Sonas therapist attends the service twice weekly. The person in charge stated that she hoped to develop this further and train one of the staff in this area. An induction plan was in place where a newly appointed staff member would work alongside a senior staff member for their first five days.

All staff interviewed and residents confirmed that there was adequate staff on duty to attend to their needs.The person in charge informed inspectors that if for any reason staff are unavailable to work, part time staff were organised to work extra shifts. This ensured that residents were familiar with the staff and the manager could have confidence that staff members were competent. Allocation of tasks was completed on a daily basis and a record maintained.

A review of staff training records confirmed that staff had access to training. Training for all staff was up to date on the prevention of fire safety (April and May2010) and evacuation and moving and handling. Two staff had attended training on 'care plan needs of the elderly' and all staff had received dementia care training and challenging behaviour (September 2010), two had attended training on infection control. Catering staff had received training on food hygiene.

The provider had commenced an appraisal system with staff. He had also commenced a process to ascertain each individual's competences and skills. He stated that he will use

this together with an evaluation of the needs of residents to guide training and development needs of staff.

A chef is on duty every day to cover for breakfast and dinner. Teas are prepared by the chef. An afternoon carer is responsible for the catering and then works as a carer after the teas are completed. Staff spoken with and residents stated that they felt there was adequate staff on duty at all times in the centre. The provider confirmed that he sometimes assisted in the kitchen in the afternoons.

Some improvements required

While there had been a lot of work completed in trying to ensure that staff files complied with the legislation, there was no evidence available of mental and physical fitness of the staff member.

Significant improvements required

Not all staff had completed mandatory training on elder abuse recognition and prevention. The provider informed staff that he would ensure that training in this area would be scheduled as soon as possible to ensure compliance with current legislation.

Closing the visit

At the close of the inspection visit, a feedback meeting was held with the person in charge to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:

Mary McCann
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

24 February 2011

Chronology of previous HIQA inspections	
Date of previous inspection	**Type of inspection:**
25 November 2009	☐ Registration ☒ Scheduled ☐ Follow up inspection ☐ Announced ☒ Unannounced
28 June 2010	☐ Registration ☐ Scheduled ☒ Follow up inspection ☐ Announced ☒ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report*

Centre:	Queen of Peace
Centre ID:	0379
Date of inspection:	11 and 12 January 2011
Date of response:	18 March 2011

Requirements

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

1.The person in charge has failed to comply with a regulatory requirement in the following respect: Not all staff had ongoing updated training on the prevention of elder abuse.	
Action required: Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 8: Protection Standard 24: Training and Supervision	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

* The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

Provider's response: An in-house study day on elder abuse has been organised for staff in April. This will complete training for all staff.	April 2011

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

The practice of medication administration by registered nurses was not in accordance with An Bord Altranais Guidelines, *Guidance to Nurses on Medication Management* (July 2007), with regards to safe practice as follows:

- times for the administration of medication were not detailed by the prescribing doctor
- medication discontinued had not been signed or dated by a medical practitioner
- there was no prescription available on-site for the medication – this was kept at the pharmacy.
- the medication policy did not detail the procedure to be adapted should a medication error or near miss occur.

Action required:

Put in place arrangements so that medication administration practices are within An Bord Altranais guidelines.

Action required:

Put in place a comprehensive policy on all aspects of medication management to reflect An Bord Altranais guidelines for registered nurses and as outlined in Standard 14.3 of the *National Quality Standards for Residential Care settings for Older People in Ireland* 2009.

Reference:

Health Act, 2007
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: From now on we ensure doctors accurately state the time at which medication is to be administered. Any medication that is being discontinued is signed and dated by the medical practitioner. A copy of each resident's monthly prescription is kept on file in the centre.	Completed March 2011

A copy of An Bord Altranais '*Guidance to Nurses and Midwives on Medication Management*' has been made available to all nurses in the nurses' station.	

3. The provider has failed to comply with a regulatory requirement in the following respect: Restraint was not managed to comply with best practice and national standards.	
Action required: Carry out a full assessment, including a risk assessment, on any resident before the use of any form of restraint is introduced to ensure it is necessary and the least restrictive option available to ensure the care welfare and protection of the resident.	
Action required: Maintain a record of any occasion on which restraint is used, the nature of the restraint and its duration.	
Action required: Obtain the consent of the resident where the resident is able to give informed consent to the application of the restraint measure.	
Action required: Maintain a record of any occasion on which restraint free time is in place to ensure compliance with best practice and standards.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Regulation 25: Medical Records Standard 21: Responding to Behaviour that is Challenging	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A comprehensive risk assessment is carried out for each resident in relation to restraint with regard to using the least restrictive option available at all times. A record is kept of all incidences of restraint which includes details of the nature of the restraint and its duration. Agreement is always obtained from a residents' next of kin on their behalf if they are unable to do so themselves. A record is kept of all restraint free time.	Completed March 2011

4. The provider has failed to comply with a regulatory requirement in the following respect:
There were no plans in place to relocate residents to a place of safety should an evacuation of the building be required.

There was no written procedure in place to outline specific staff responsibilities in the event of any evacuation of the building.

Individual risk assessments had not been completed detailing a specific plan to ensure safe timely evacuation of all residents.

Action required:
Update staff of the evacuation procedures which ensures the safe placement of all residents. Ensure staff are aware of specific responsibilities should the need to evacuate arise for example reporting arrangements.

Action required:
Update written procedures in relation to evacuation of the premises to include details of a place of safety for residents

Action required:
Complete individual evacuation plans for all residents.

Reference:
Health Act, 2007
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Update training has been organised to update staff on evacuation procedures in order to ensure the safe placement of all residents and to ensure they are aware of specific responsibilities should the need to evacuate arise. Written procedures in relation to evacuation of the premises are being devised. All staff currently have up to date fire safety training. Currently in discussion with the local hotel to agreed use of their hotel as a contingency arrangement should the need arise.	May 2011

5. The provider has failed to comply with a regulatory requirement in the following respect: Directional signage, appropriate fire procedures and exit directions were not available at strategic points throughout the building.	
Action required: Put in place fire action notices to include procedures to be followed in the event of fire, directional advice for fire evacuation routes and assembly points.	
Reference: Health Act, 2007 Regulation 32: Fire Precautions and Records Regulation 6: General Welfare and Protection Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The centre currently has appropriate exit signs located throughout the building and extra signs are being made available at strategic points throughout the building.	April 2011

6. The provider has failed to comply with a regulatory requirement in the following respect: There were inadequate storage facilities for the cleaning trolley. There was no staff changing facilities.	
Action required: Provide suitable storage in the designated centre.	
Action required: Provide suitable staff changing facilities.	
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Plans to extend the nursing home contain additional storage facilities for cleaning equipment and a staff room. Currently utilising small storage area for mops.	Under review Dependant on new build. Planning permission has been obtained.

7. The provider has failed to comply with a regulatory requirement in the following respect:
Sufficient documentary evidence of systems developed to review the quality and safety of care provided to residents were not available. Therefore there was no evidence of learning and improving practice as a result of monitoring for example accidents, care practices, medication management, service provision, or resident satisfaction in order to inform quality improvements in the centre.

Action required:
Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.

Reference:
Health Act, 2007
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A quality assurance questionnaire for service users and relatives of and/or friends has been compiled in order to ensure sufficient monitoring of quality improvements necessary in the centre.	May 2011

8. The provider has failed to comply with a regulatory requirement in the following respect:
The statement of purpose did not reflect all of the requirements as specified in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) 2009 (as amended) For example, the number and size of rooms available, the staff allocation or whether the centre would accommodate emergency admissions. It also failed to address the age range of residents the centre wished to accommodate.

Action required:
Revise the statement of purpose to meet the requirements of the Regulations.

Reference:
Health Act, 2007
Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The Statement of Purpose is currently being revised to include all the necessary information so as to ensure it includes all of the	May 2011

requirements as specified in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) 2009 (as amended).	

9. The provider has failed to comply with a regulatory requirement in the following respect: Some staff did not have verification on their personnel files that they are physically and mentally fit for the purpose of the work that they are to perform.	
Action required: Obtain evidence of medical and physical fitness and update staff file including all information as required in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) 2009 (as amended).	
Reference: Health Act, 2007 Regulation 18: Recruitment Standard 22: Recruitment	
Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response: Documentation of medical and physical fitness of all staff has been obtained by their GP's and is contained in their staff files.	Completed.- March 2011

11. The provider has failed to comply with a regulatory requirement in the following respect: Residents and their significant other were not consistently involved in the care planning process. Evaluation of the care plan was poorly documented.
Action required: Set out each resident's needs in an individual care plan developed and agreed with the resident.
Action required: Ensure that when a care plan is evaluated that there is adequate documentation of the process that shows clearly any changes and also documents if there are no changes to allow for a quality evaluation.
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 10: Assessment Standard 11: The Resident's Care Plan

Please state the actions you have taken or are planning to take following the inspection with timescales:	Timescale:
Provider's response: At the Queen of Peace we strive to ensure all Residents and their next of kin are included in all aspects of their care and care planning.	Completed for existing residents March 2011 and ongoing.

11. The provider has failed to comply with a regulatory requirement in the following respect:
No non verbal communication system was in place. It was not possible to facilitate and encourage communication with residents who could not express themselves verbally.

Action required:
Devise an alternative communication system that ensures that all residents are facilitated and encouraged to communicate enabling them to participate in the activities and running of the centre.

Reference:
Health Act 2007
Regulation 11: Communication
Standard 17: Autonomy and Independence

Please state the actions you have taken or are planning to take following the inspection with timescales:	Timescale:
Provider's response: We are in the process of organising staff training with specific regard to non-verbal communication which will assist residents who have difficulties in communicating their needs and in turn ensure that all residents are facilitated and encouraged to communicate, thus enabling them to participate in the activities and running of the centre.	May 2011

12. The provider has failed to comply with a regulatory requirement in the following respect:
Adequate precautions were not taken to control the potential risk of cross infection in that there was no clean area to store cleaning equipment.

Action required:
Put in place suitable practices in infection control in accordance with current Regulations and best practice guidelines.

Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All cleaning staff have been made aware of the importance of infection prevention and control in relation to the storing of cleaning equipment and the implications associated with cross infection. Suitable storage space is available in the sluice room for cleaning solutions.	Completed March 2011

13. The provider/ person in charge has failed to comply with a regulatory requirement in the following respect: Records of residents' petty cash were not signed by two staff and the resident or their significant other. A record of residents' personal property was not kept up to date.
Action required: Maintain an up-to-date record of each resident's personal property that is signed by the resident and two members of staff.
Action required: Put in place a transparent and traceable system for the management of residents' petty cash.
Reference: Health Act, 2007 Regulation 7: Residents' Personal Property and Possessions Standard 9: The Resident's Finances

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: An up-to-date record of each resident's personal property is now available. It is signed by the resident or their next of kin and two members of staff.	Completed March 2011

14. The provider/person in charge has failed to comply with a regulatory requirement in the following respect:
Where a resident sustained a fall un-witnessed or when observed to hit their head on falling, neurological observations were not re corded to determine if a head injury had been sustained and/or the level of consciousness affected.

While there was a comprehensive set of operating policies available, some staff spoken with were unaware of the contents or existence of specific policies.

Action required:
Ensure a high standard of evidenced based nursing practice is met with regard to residents who have sustained a fall.

Action required:
Provide staff with access to education and training on the operating policies and procedures to enable them to provide care in accordance with contemporary evidenced-based practice.

Reference:
Health Act, 2007
Regulation 6: General Welfare and Protection
Regulation 17:Training and Staff Development
Standard 8: Protection
Standard 24: Training and Supervision

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A meeting has been held which has been attended by all staff to discuss the importance of this issue. It has been highlighted that if a resident sustains any injury due to a fall or other incident, neurological observations are to be recorded immediately to determine if a head injury had been sustained and/or the level of consciousness affected. We have also revised our incident report form to include additional information on the Residents vital signs following an incident. Staff training on risk management and patient safety is being sought with a view to providing staff with a clear awareness of patient safety and how it integrates into the quality safety and risk framework.	May 2011

Recommendations

These recommendations are taken from the best practice described in *the National Quality Standards for Residential Care Settings for Older People in Ireland* and the registered provider should consider them as a way of improving the service.

Standard	Best practice recommendations
Standard26: Health and Safety	Compile a missing person description profile for each resident to include a recent photo of the resident to assist should a resident go missing. **Provider's response:** A missing person's profile is being compiled which contains details on each resident for example, a recent photograph, a detailed description of the resident and additional information which would assist in the event of a resident going missing.
Standard 3: Consent	Provide an independent advocate to residents to assist them in making decisions. **Provider's response:** An independent volunteer advocate who visits once a week is available in the Home who can assist residents in making decisions if necessary.
Standard 2: Consultation and Participation	Complete a life history/life story for each resident and use the information gathered to plan and personalise the activity programme. **Provider's response:** Life story work is being introduced to the centre for each resident. When this is completed the information gathered will be used to plan and personalise the activity programme.
Standard 8: Protection	Dedicated elder abuse officer details to be added to protection policy **Provider's response:** Our protection policy is currently been revised to include relevant details of the elder abuse officer.
Standard 25: Physical Environment	Provide a visitors room separate from the smoking room **Provider's response:** Currently plans are ongoing to extend the nursing home, which include a spacious visitors' room.
Standard 26: Health and	Make arrangements for a fire officer from the statutory fire authority to conduct a familiarisation visit.

Safety	**Provider's response:** The fire officer has been contacted regarding carrying out a familiarisation visit and we are awaiting his response.
Standard 29: Management Systems	Staff meetings should take place on a regular basis. **Provider's response:** A staff meeting is scheduled to take place every three months. The minutes from staff meetings are made available on the staff notice board in the nurses' station and also contained in a file.
Standard 2: Consultation and Participation	Continue to try and set up a residents' committee **Provider's response:** The community development officer for Co. Mayo has agreed to assist us in setting up a residents' committee and plans for this are under way.
Standard 1: Information	Name badges to be worn by all staff. **Provider's response:** We are in the process of obtaining name badges for all staff.
Standard 28 : Statement of Purpose and Standard 1: Information	Compile two separate documents one entitled the Statement of Purpose and the other The Residents' Guide. **Provider's response:** These documents are currently being changed with a view to becoming two separate documents.
Standard 13: Healthcare	Research and explore the availability of wound care advice to the centre. **Provider's response:** We have contacted the tissue viability nurse and now have access to information and advice on wound care.

Any comments the provider may wish to make:

Provider's response:

Thank you for carrying out this inspection. We acknowledge your comments and recommendations. We appreciate your commitment to the care of the older person and we commend you on your attention to detail.

Provider's name: Raffick G Mohidin
Date: 18 March 2011