Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated Centres under Health Act 2007

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Queen of Peace Centre
Centre ID:	0085
Centre address:	6-8 Garville Avenue Rathgar Dublin 6
Telephone number:	01 4975381
Email address:	spcqueen@eircom.net
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Sisters of St. Paul of Chartres
Person authorised to act on behalf of the provider:	Sr. Rose Nuval
Person in charge:	Sr. Fabiola Pak
Date of inspection:	10 and 11 July 2012
Time inspection took place:	**Day-1 Start:** 07:50 hrs **Completion:** 17:40 hrs **Day-2 Start:** 07:50 hrs **Completion:** 17:00 hrs
Lead inspector:	Gary Kiernan
Support inspector:	Linda Moore
Type of inspection	☐ **announced** ☒ **unannounced**
Date of last inspection:	1 July 2011

About inspection

The purpose of inspection is to gather evidence on which to make judgements 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 18 outcome statements. The outcomes set out what is expected in designated centres.

Outcome 1 *There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the statement of purpose, and the manner in which care is provided, reflect the diverse needs of residents.*
Outcome 2 *The quality of care and experience of the residents are monitored and developed on an ongoing basis.*
Outcome 3 *The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure*
Outcome 4 *Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.*
Outcome 5 *The health and safety of residents, visitors and staff is promoted and protected.*
Outcome 6 *Each resident is protected by the designated centre's policies and procedures for medication management.*
Outcome 7 *Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.*
Outcome 8 *Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.*
Outcome 9 *Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discreet and sensitive manner.*
Outcome 10 *Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.*

Outcome 11 *Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.*
Outcome 12 *Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.*
Outcome 13 *The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.*
Outcome 14 *There are appropriate staff numbers and skill-mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.*
Outcome 15 *The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.*
Outcome 16 *The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).*
Outcome 17 *A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*
Outcome 18 *The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.*

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

The inspection report is available to residents, relatives, providers and members of the public, and is published on www.hiqa.ie in keeping with the Authority's values of openness and transparency.

About the centre

Location of centre and description of services and premises

The Queen of Peace Centre was established in 1972 as a home for retired men and women. It was established by a religious order that live in the adjoining convent. It became a nursing home in 1994 and provides 45 residential places to male and female residents over the age of 18. The centre provides 24 hour nursing care and at the time of inspection there were 44 residents and all were over 70 years of age. The centre does not admit residents with dementia but some residents, who have lived there for over a decade, have dementia-related conditions. There is self-contained, independent living accommodation adjacent to the grounds of the centre.

The facility is a three-storey building and there are four sets of stairs and a lift access to all floors. The double doors at the entrance open into a hall with a glass window to the receptionist's office on the right. The large dining room, which was built in 2000, is directly opposite the front hall, with a kitchen next to it. The corridor to the right leads to the provider's office, three administrative offices, a visitors' room and a male and female toilet.

All bedrooms are single rooms and are located on the first and second floors. The first floor provides accommodation for 24 residents who require higher levels of support and supervision. On the first floor five bedrooms have en suite toilet and shower facilities and the remaining 19 have a wash-hand basin. There are two wheelchair accessible, assisted toilets one of which has an assisted shower and four further toilets. There is also an assisted bathroom with bath and shower. Facilities for residents include a large activity/sitting room, visitors' room, a kitchenette and a veranda which is used as a smoking area. The first floor also has a treatment room, a kitchenette, medication room, a sluice room with bedpan washer, a utility room and a cleaning room.

The second floor provides accommodation for 21 residents with varied dependency levels. Of these rooms, eight have en suite toilet and shower facilities and the remaining thirteen have wash-hand basins. There are three toilets one of which is assisted and there is a further assisted shower room on this floor. Facilities for residents on this floor include a kitchenette, library, visitor's room, oratory and a veranda which is used as a smoking area. The person in charge has an office on this floor, and there is a nurses' office and staff toilet and staff shower facilities. A sluice room with bedpan washer and a storage room are also provided on this floor.

The ground floor also contains the laundry and a sewing room, maintenance room, main kitchen and storage rooms. Separate toilet and changing facilities are provided for the catering staff.

The centre is situated on a spacious site and there are well maintained gardens at the back of the building. Double doors on the ground floor open into the garden. The doors are operated by an electronic release button. The garden is not secure as the road can be reached from one side of the building. The centre is connected to the convent by a link corridor from the first floor and is accessible to the religious order via electronic door security. There is ample car parking at the front of the building.

The Queen of Peace Centre is located on Garville Place a cul de sac off Garville Avenue, in Rathgar, Dublin. It is close to the local church and accessible by bus routes.

Date centre was first established:	1994
Date of registration:	8 December 2011
Number of registered places:	45
Number of residents on the date of inspection:	44

Dependency level of current residents as provided by the centre:	**Max**	**High**	**Medium**	**Low**
Number of residents	4	24	11	5

Gender of residents	**Male (✓)**	**Female (✓)**
	✓	✓

Management structure

Queen of Peace is owned by the Sisters of St Paul of Chartres. The Order has another community of Sisters in London and its headquarters are based in Rome. The nominated Provider is Sr. Rose Margaret Nuval. The Person in Charge is Sr. Fabiola Pak and she reports to the Provider. The Assistant Director of Nursing (ADON), Sr. Anastasia Lee, reports to the Person in Charge. Nurses report to the ADON. Nurses supervise the care assistants. Laundry, cleaning, reception and maintenance staff report to 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	3	9	4	4	3	2*
Number of staff on duty at night		1	3**				1***

* The provider and the maintenance person
** One care assistant works a “twilight” shift and finishes at 10.00 pm
*** The security person

Summary of compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

This report sets out the findings of an unannounced inspection. This inspection took place over two days. As part of the inspection, inspectors met with residents, relatives, and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

This was the third inspection of the Queen of Peace Centre by the Health Information and Quality Authority (the Authority) Social Services Inspectorate. Previous to this, a follow up to the registration inspection was carried out on 1 July 2011. The registration inspection was carried out on 30 and 31 August 2010. The follow up inspection reported that 10 of 13 actions had been completed and three had been partially completed. Further to this follow up inspection, actions were issued in relation to staffing levels at night, residents accessing the stairwells and the statement of purpose. The Reports for these inspections can be accessed at www.higa.ie.

This inspection identified a number of areas of risk about which inspectors had concerns. An immediate action plan was issued on 13 July 2012 requiring the provider to address a number of matters. These matters referred to residents accessing the stairwells and accessing the exterior of the building, lack of risk assessment of a resident who smoked in bed, the management of nutrition and supervision of two residents who were at a high risk of falling. The provider responded to this immediate action plan and provided information indicating that measures were taken to address these matters. Inspectors found that overall risk was not managed well within the centre. The centre's own policy on risk management was not being implemented. Inspectors identified other areas of risk including access to verandas on the first and second floor, the maintenance of the emergency lighting system and staff that did not have up to date fire safety training.

Overall inspectors found that staff were committed to providing a high standard of care and the needs of residents were being met. However, improvements were required in the assessment and care planning process. Inspectors also identified a number of improvements which were required in the area of restraint. The provision of opportunities for residents to participate in meaningful and engaging activities was found to be inadequate.

Inspectors found that there were systems in place to protect residents from abuse but some improvements were identified in relation to the policy, the provision of training and the procedures in place for investigating all allegations of abuse.

The provision of staffing levels at night was not in accordance with the information which had previously been provided to the Authority. Inspectors found that staffing levels were not adequate at night.

The managements of patients' medical records was not appropriate. The records relating to staff and volunteers were also found not to be in compliance with the Regulations.

Positives aspects of care were also noted. Residents had good access to general practitioners (GPs) and other allied health professionals. Residents were encouraged to be independent and to maintain contacts and interests outside the centre. Residents from the adjacent independent living units joined in the dining experience and visited residents in the centre.

The building was suitable for its stated purpose and provided large communal spaces and rooms where residents could spend time with relatives in private. All residents were provided with single rooms. There was a large oratory, a library and residents' spiritual needs were very well met.

Compliance with 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. Statement of purpose and quality management

Outcome 1
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the statement of purpose, and the manner in which care is provided, reflect the diverse needs of residents.

References:
Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

Inspection findings
Inspectors read the statement of purpose which set out the facilities provided and the intended aims, objectives and ethos of the centre.

The statement of purpose had been drafted in line with the requirements of the Regulations. However, it did not outline all the precautions taken in relation to fire and it did not accurately outline the centre's complaints procedure.

Outcome 2
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

References:
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Inspection findings
Inspectors found that there were systems in place to audit and monitor the quality of care provided to residents but these systems could have been made more robust. Inspectors saw that the centre had developed systems to audit falls, medication management, care files and to monitor the weights of all residents on a monthly basis. A cleaning and infection control audit was carried out by an external consultant in March 2012 and inspectors saw that a further audit was planned for September 2012. In some cases this information was used to improve the service. For example, the person on charge explained that the medication management audit had been used to update the medication administration sheet and make it more user-friendly.

However, overall there was no formal system in place to ensure that audit findings were comprehensively reviewed and used to bring about changes. The person in charge stated that she did not always review the audit findings and there was no evidence that they were discussed at staff meetings.

Information was also gathered on individual incidents, accidents and complaints which were all individually managed and reviewed. Inspectors saw that in the case of incidents and accidents efforts were made to analyse this information in order to identify trends. However, in the case of complaints there was no process in place to review the information gathered in order to identify trends and improve practice at the centre level.

The person in charge said that she used resident and relative surveys, in the form of a written questionnaire, in order to gather information about the experience of the residents in the centre. Inspectors saw that a survey had been carried out in June 2011 and this had been used to make changes to the food offered to residents. The person in charge stated that she aimed to carry out this process biannually. However a survey had not yet been completed in 2012.

Outcome 3
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Inspection findings
The complaints process was generally in line with the requirements of the Regulations. However, a detailed record of all complaint investigations was not maintained. Inspectors were shown the most recent version of the policy which described how a complaint could be made and also the process for independent appeals. The complaints procedure was displayed in a prominent location in the centre as required by the Regulations.

Inspectors reviewed the complaints folder and found some complaints were recorded in detail, identified the complainant, the issue and the action taken. However, these records did not record the satisfaction of the complainant with the outcome of the complaint. In the case of one written complaint received in October 2011 there was no record of any investigation made, of the outcome of the complaint or of any actions taken.

2. Safeguarding and safety

Outcome 4
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.

References:
Regulation 6: General Welfare and Protection
Standard 8: Protection
Standard 9: The Resident's Finances

Inspection findings

Inspectors found that there were systems in place to prevent and detect elder abuse. However, the policy on elder abuse was not detailed enough and staff did not know how to comprehensively investigate an allegation of elder abuse.

Inspectors reviewed the centres policy on the prevention, detection and response to elder abuse and found that it gave guidance to staff on the types of abuse and the procedures for reporting alleged abuse. However, the policy did not guide staff on the procedures to follow when investigating an allegation of elder abuse.

Inspectors reviewed the details of an investigation of alleged verbal abuse made by a resident. Inspectors found that the matter was promptly responded to, and action was taken to investigate the matter and protect the resident. However, the investigation was not recorded in detail and did not describe the measures which were put in place to protect the resident while the investigation was ongoing. No witness statements were recorded.

When questioned, the person in charge and the ADON knew about the types of elder abuse and their responsibilities to protect residents. However, they could not describe in detail how they would go about investigating an allegation of abuse and the measures that they would take to protect the resident while an investigation was ongoing. In addition, inspectors found that one staff nurse did not demonstrate the appropriate knowledge or understanding of the correct response and procedures to follow if an allegation of abuse was made. Inspectors found that a lack of understanding of this matter could put vulnerable residents at risk.

Inspectors found that there was a system in place to provide training to all staff in elder abuse on a yearly basis and many staff confirmed that they had attended this training and were knowledgeable about their responsibilities. However, inspectors indentified four staff who had not attended this training.

All residents spoken to said that they felt safe and secure in the centre.

There was an informative policy on the management of residents' finances and property, which clearly outlined the arrangements for the safekeeping of residents' property. The centre managed small amounts of money for some residents. Inspectors reviewed the arrangements in place to manage residents' finances and

saw that all transactions were recorded and signed by two witnesses. Some residents were taking care of their own money and the staff nurse in charge stated that all of these residents had been provided with locked storage.

Outcome 5
The health and safety of residents, visitors and staff is promoted and protected.

References:
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Inspection findings
The provider did not have adequate systems in place to protect the health and safety of residents, staff and visitors.

The previous inspection carried out by the Authority highlighted the risk of residents with a cognitive impairment accessing the stairwells. Inspectors also noted that an independent health and safety consultant carried out an audit in November 2011 and reported on the need to control access to the stairwells. Inspectors were concerned that steps had not been taken to manage this risk. Inspectors were also concerned that the doors on the ground floor were unsecured and allowed direct access to the unsecured garden and to the external street. Inspectors questioned staff and were told about a resident who was at a high risk of falls and who was likely to wander. Inspectors were also told about a further resident who was mobile and who had recently become confused and could not recognise the surroundings. An immediate action plan was issued on 13 July 2012 requiring the provider to address these risks.

Inspectors indentified a further resident who was exposed to an unacceptable level of risk. Inspectors were informed that there was only one resident who smoked in the centre. Inspectors visited this resident's room and found that the resident smoked in bed. The resident also kept cigarettes and lighter on the bedside locker. No risk assessment had been carried out of this resident's ability to safely smoke independently or with assistance. Similarly the risk posed by keeping the cigarettes and lighter in an unsecured location had not been assessed. The immediate action plan issued on the on 13 July 2012 also required the provider to address this matter. Information was subsequently provided to the Authority indicating that this matter, and those outlined above, had been addressed.

A smoking veranda was provided on the first and second floor. Inspectors noted that these areas had been provided with barrier around the sides. At the time of inspection these verandas were open and accessible to residents who were mobile. However, a risk assessment had not been carried out in order to assess the risk of residents accessing these areas.

There was a health and safety statement in place and a risk management policy dated June 2011. However, this policy was not implemented. A safety committee had not been set up and a system of internal health and safety audits had not been initiated in line with the centre's policy. The policy did provide guidance to staff on the identification and management of risk, including clinical risk, within the centre. The risk management policy also identified the risks specified in the Regulations such as the risk of residents absconding.

The safety policy had identified a number of hazards and the associated control measures for each area of work within the centre. However, there were no formal processes in place to ensure that these controls were routinely monitored, as prescribed in the centre's policy document. The person in charge showed inspectors evidence that an external consultant was carrying out a yearly audit. However, as highlighted above, all of the recommendations from this audit were not being addressed. The maintenance person said that he carried out undocumented health and safety checks, including checks on the hot water system on a weekly basis. The maintenance person could describe the mechanisms that were in place to control hot water temperatures and radiator temperatures. However, appropriate checks with a thermometer were not being carried out. Inspectors checked a number of hot water temperatures and found them to be satisfactory.

Inspectors noted a number of residents who were transferred in wheelchairs which did not have footrests. Inspectors observed that these residents had to lift their feet off the floor during transfer. Inspectors were concerned that this process could put the residents at risk of injury.

Inspectors reviewed the emergency plan and found that while it provided a lot of detailed information it had not been maintained up to date. The plan identified another centre, which is no longer operating, as place of evacuation, in the event of a serious incident in the centre.

The inspectors reviewed the fire records which showed that all fire equipment had been regularly serviced. The fire extinguishers were serviced annually and quarterly servicing of the fire alarms was also carried out by external fire safety consultants. The emergency lighting system had not been serviced since 2010, according to the records which were shown to inspectors. Inspectors were shown a daily, signed record of checks on fire exits which had not been completed since February 2012. The maintenance person said that he continued to check the exits on a daily basis without documenting them. A documented weekly check on fire doors was in place.

Inspectors saw records which showed that training in fire evacuation and fire safety procedures was routinely provided by an external consultant. The person in charge and the maintenance person stated that they also carried out in-house fire drills with staff biannually, following this training. However, these fire drills were not documented and there was no system in place to identify which staff had a attended fire drills. Inspectors spoke to a number of staff members regarding fire safety and evacuation procedures and found that all were knowledgeable about what to do in the event of the fire alarm going off. Inspectors examined the fire safety training matrix which the person in charge maintained and found that three long serving

night staff had not attended fire safety training since 2010. A further four new staff had also not attended fire safety training.

Inspectors observed that one of the stairwells which led from the oratory and communal day room was being used as a storage area for a number of items including seating and disused furniture. While the means of egress was not obstructed, inspectors noted that these items were combustible. The health and safety audit referred to above and indicated the need to remove these items however this had not been carried out. Inspectors noted the maintenance person removing these materials from the stairwell during day two of the inspection.

Inspectors noted that infection control practices were adequate. A comprehensive infection control policy was in place to guide staff in this area. There were arrangements in place for the segregation and disposal of waste including clinical waste. Nursing staff and care assistants were observed following correct hand hygiene and using gloves, hand gels and aprons appropriately. The sluicing facilities were maintained in a clean and satisfactory condition. Wall mounted dispensers containing hand sanitising gel were located at the entrance door and throughout the building.

The provider and person in charge had put in place controls to monitor all visitors to the building. A visitors' book was maintained and completed daily. There was a CCTV system to monitor visitors, residents and staff in the communal hallways and the entrance to the building.

Outcome 6
Each resident is protected by the designated centre's policies and procedures for medication management.

References:
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Inspection findings
In general inspectors found that the processes in place for the management of medication were in accordance with current guidelines and legislation. However, some improvements were required.

There were comprehensive medication management policies in place which provided clear guidance to staff in areas such as general principles of medication administration, self administration, storage and crushing of medications, refusal and withholding of medications and medication errors.

Inspectors reviewed the prescription sheet for a number of residents and found that the general practitioner (GP) signed for each medication individually. The majority of resident's medications were reviewed on a planned regular basis by the GP. However, the review date was not recorded in all cases. In some cases it was recorded on the prescription sheet by the nursing staff. In the case of another

prescription sheet, there was no date to indicate when the medications had been reviewed. The person in charge stated that she was satisfied that this review had taken place the week previous to inspection but the review date had been overlooked.

Inspectors accompanied a nurse at the start of a medication round and discussed medication management practices. The nurse demonstrated competence and knowledge when outlining the procedures and practices for medication management and administration. The nurse had a lockable medication trolley and this was locked when unattended. There were colour photos of residents on the administration charts and the nurse recorded and signed each medication administered.

Inspectors noted that the process for prescribing medications to be crushed did not meet An Bord Altranais guidelines. Medications which were to be crushed were not accompanied by a prescribing signature from the GP. In the case of one prescription sheet, inspectors observed that the maximum dose in 24 hours for a PRN (as required) medication was not stated.

Inspectors saw that there was a system in place to record medication errors and to inform the ADON when they occurred but there was no formal system of reviewing medication errors in order to implement preventive controls. Inspectors saw that there was a policy and procedure in place to manage medication errors. A central folder was maintained. Inspectors reviewed the details of a number of medication errors. Inspectors saw that there was a record maintained of what occurred e.g. incorrect timing of administration. All sections of the error form were not consistently completed, for example, the “resident outcome” section was omitted in two of forms reviewed. The ADON was responsible for overseeing all errors and the record indicated that she had been informed. However, inspectors believed that this system could have been made more robust if the ADON had signed this form to indicate that the error had been reviewed and if any changes had been made to prevent future reoccurrence.

Inspectors saw that there was a system in place to audit medication management procedures twice yearly. The ADON was responsible for carrying out this procedure. The records showed that a number of nurses had carried out medication management training in September 2011.

Medications that required special control measures (MDAs) were carefully managed and kept in a locked medicinal press within a locked cupboard in keeping with the Misuse of Drugs (Safe Custody) Regulations, 1984. Nurses kept a register of controlled drugs. Two nurses signed and dated the register and the stock balance was checked and signed by two nurses at the time of administration during the day shift and at the change of each shift. Administration of controlled drugs at night was signed by a nurse and a care assistant. Inspectors checked the stock balances for two controlled medications and found them to be accurately accounted for.

The medication management policy was not fully implemented in relation to one resident who had been prescribed a PRN psychotropic medication. The policy stated that the circumstances when such medications should be used must be described along with the interval between doses and the review date. However, inspectors found that this information was not recorded in order to guide staff on when this medication should be used. Healthcare needs are further discussed under Outcome 7.

3. Health and social care needs

Outcome 7
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

References:
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Inspection findings
The centre had sufficient GP cover, and there was an out-of-hours medical service available. A review of residents' medical notes showed that GPs visited the centre regularly. There was a system in place for residents to be reviewed every three months by their GP and there was documentary evidence to support this. Residents told inspectors that they had access to their GP when necessary and they felt their health needs were well monitored. The residents had access to the services of health care professionals such as chiropodists, tissue viability consultant and a psychiatric consultant, as required. The physiotherapist visited the centre once per week. Records of referrals and treatments given were maintained on residents' files.

Inspectors found that staff knew the residents well and could describe how residents should be cared for. Inspectors reviewed a number of care plans and noted that some improvements were required in the care planning process. Inspectors saw that the pre-admission assessment form and initial nursing assessment were not carried out for all residents in a comprehensive way. Additional risk assessments were carried out including falls, risk of developing pressure ulcers, continence and nutrition. Inspectors found that these assessments were generally reviewed on a three-monthly basis. There were monthly records which showed that observations such as pulse, blood pressure and weight were routinely checked. However, care plans were not always developed in response to these assessments. For example, in the case of two residents who were identified as being at risk of poor nutrition a care plan had not been developed. There were also examples of care plans not being followed - an instruction in the care plan for a resident indicated two hourly turning at night - this was not being followed.

In the case of the resident, described in outcome six, who was prescribed PRN psychotropic medications, staff stated that this medication was given in order to help the resident to sleep. The records showed that this medication was administered at night when the resident was agitated. However, there was no care plan in place to guide staff on the care of this resident when agitated or to guide the use of this medication in a consistent manner. There was no description of any alternatives which could be considered. The care plan did not outline the appropriate circumstances in which to use these medications and an assessment had not been carried out to determine if the use of these medications constituted restraint.

Inspectors were concerned about the supervision of two residents who were at a high risk of falling. Both of these residents had a history of falls and spent a lot of time in their bedrooms alone. While they had been provided with one-to-one private carers for a number of hours per day, six days per week, there was no formal system to supervise and monitor the residents outside these hours. One of these residents had been inappropriately restrained on day one of the inspection in order to prevent falls. This matter is outlined below. However, the resident was not reassessed following the removal of this restraint in order to determine the safe, alternative interventions which were necessary to keep the resident safe. Inspectors noted that the care plans were not detailed enough to guide the care of this resident when there was no one-to-one supervision.

In the case of the other resident, whom inspectors were concerned about, the care plan stated “needs constant supervision”. This resident was blind and was observed in her room alone and there was no description of how this resident would be supervised at all times in order to prevent falls. Regular checks of the resident were not documented. Staff spoken to were aware that both residents were at a high risk of falling but did not know how frequently they should be checked. An immediate action plan was issued in relation to these two residents on 13 July 2012. Information was subsequently provided confirming that this matter had been addressed.

Inspectors reviewed the overall number of falls per resident over a 12 month period and found that this figure fell within normal, expected parameters as established in relevant literature. Overall there was a downward trend in the number falls. Inspectors noted that falls risk assessments were completed and on residents' files. However, inspectors noted that individual falls were not always well managed. For example, post falls risk assessments were not always completed in accordance with the centre's own policy and inspectors noted a small number of falls involving head impact where neurological observations had not been completed or had only partially been completed.

Inspectors had concerns about the management of nutrition within the centre. Inspectors were told about two residents who had lost substantial amounts of weight. One resident had lost 13 kg over a two month period while another resident had lost 8 kg over a month. Staff explained that the resident with the greater weight loss had been receiving end-of-life care and had been in hospital for a period in June but had since improved. Both residents were scheduled to be seen by a dietician on 26 July 2012. However, neither of these residents had their weights checked on a weekly basis, in accordance with the centre's own policy on nutrition, and a daily record of dietary intake had not been initiated. One of these residents had been seen by the GP in May 2012 while the other had been seen 11 days previous to inspection. An immediate action plan was issued on 13 July 2012 in relation to this matter. A satisfactory response to the immediate action plan was also received in relation to this matter.

The management of restraint required improving. Inspectors observed a resident on day one of inspection who was inappropriately restrained in a recliner chair. The resident did not have an assessment or care plan in place for the use of restraint. Therefore, there was no guidance to staff regarding the care of the resident whilst in restraint, including periods of mobilisation and periods of release.

The person in charge stated that the policy on restraint had recently been updated. However, inspectors noted that it had not been reviewed in the context of recent national guidance on restraint. For example, the policy did not guide staff on the use of lap belts.

Inspectors noted that a number of residents were using bedrails and found that risk assessments were taking place in order to determine their suitability for the resident. In most cases the resident had signed a consent form for the use of bedrails. However, a record that alternatives were being considered was not available on the care files reviewed. There was a system in place to check all residents who used bedrails at hourly intervals during the night and these checks were documented. Inspectors believed that this system could have been made more robust if there was a formal system of supervision in place for residents using bedrails during the day.

There were systems in place for the management of wounds within the centre. Two residents were reported as having chronic leg ulcers. Inspectors found that there was a wound management policy in place and residents had access to specialists in wound care when necessary. There was also evidence that residents were prescribed supplements when necessary. Inspectors reviewed one of these residents and found that they had recently attended a specialist wound care clinic and there was a wound

management chart in place. A wound care plan had not been developed and staff said they referred to the written instructions of the wound clinic instead. However, inspectors noticed that the nursing staff were not adhering to the treatment regime specified by the specialist in wound care. The nursing staff stated that they had sought advice from the person in charge and contacted the wound clinic in relation to this. However, there was no record of this. As a result different staff gave conflicting versions of how care should be given. Inspectors believed that this process could have been improved if a care plan had been developed for each wound and updated as appropriate.

A small number of residents had behaviours that challenge. Inspectors found that there was an informative policy in place to guide the care of these residents. However, this policy was not being implemented. In the case of a resident who had behaviour that challenges there was no care plan in place to comprehensively guide staff on how to care for this resident. While staff could describe the techniques they would use to calm this resident, there was no chart in place to monitor and record the triggers for these behaviours. Therefore there was no meaningful care plan in place to describe the interventions to be used to manage the behaviour and inform future preventive measures.

There was a schedule of activities in place for residents. However, inspectors felt that this could have been improved. One care assistant was allocated one hour per day on five days per week in order to coordinate and supervise activities in the centre. Inspectors did not believe that this was adequate to organise and coordinate meaningful and engaging activities for all residents. Inspectors saw that the schedule included exercise classes, bingo and quizzes. However, there were very few dementia-specific activities and there was no formal structure in place to ensure that the wider staff were involved in facilitating activities and providing one-to-one interaction with those residents who would benefit from this. One resident commented to inspectors that there was nothing interesting to do during the day. Social assessments had not been carried out with residents since 2010 and social care plans had not been developed. There was also daily mass and rosary each afternoon for those residents who wished to participate. Inspectors noted that the majority of residents attended mass daily.

Outcome 8
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

References:
Regulation 14: End of Life Care
Standard 16: End of Life Care

Inspection findings
There was a comprehensive and informative policy on end-of-life care which was centre-specific.

At the time of inspection no resident was receiving end-of-life care. Training in end-of-life care had been provided to some staff and the nurse in charge stated that the centre had very strong links with the local hospice team. She also stated that residents at this stage of life had regular access to a priest or other religious ministers as required. Family members who wished to stay overnight were facilitated.

Outcome 9
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discreet and sensitive manner.

References:
Regulation 20: Food and Nutrition
Standard 19: Meals and Mealtimes

Inspection findings
Inspectors were satisfied that residents received a nutritious and varied diet and mealtimes were unhurried, social occasions that provided opportunities for residents to interact with each other and staff. Inspectors spent time in the dining rooms during lunch and found that there was a pleasant atmosphere and food was hot and well presented. Some residents from the adjacent independent living units also dined in the main dining room and this added to the social atmosphere. Residents had two choices of main course and of dessert. However, staff and residents confirmed that all requests for a particular meal were facilitated. Residents' choice regarding seating arrangements was accommodated. Staff assisted those residents requiring help in a discrete and respectful manner.

Inspectors visited the kitchen and spoke to the chef. The kitchen was well equipped and there were ample stores of fresh and frozen food. The chef was very knowledgeable regarding residents' likes, dislikes and special dietary needs. The chef knew that residents well and records were maintained in the kitchen on residents' food requirements. Inspectors saw that some residents required modified consistency diets and these residents had the same choice as other residents. These meals were well presented in individual portions.

4. Respecting and involving residents

Outcome 10
Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

References:
Regulation 28: Contract for the Provision of Services
Standard 1: Information
Standard 7: Contract/Statement of Terms and Conditions

Inspection findings
Inspectors reviewed the contracts in place for two residents and found that they had been agreed and signed. The contracts clearly set out the services which residents could expect to receive and the charges for additional services were also included.

Outcome 11
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.

References:
Regulation 10: Residents' Rights, Dignity and Consultation
Regulation 11: Communication
Regulation 12: Visits
Standard 2: Consultation and Participation
Standard 4: Privacy and Dignity
Standard 5: Civil, Political, Religious Rights
Standard 17: Autonomy and Independence
Standard 18: Routines and Expectations
Standard 20: Social Contacts

Inspection findings
Residents' religious and civil rights were supported. There was an oratory in the centre which residents and relatives could use for prayer and reflection. Mass took place on a daily basis and residents who did not want to attend mass were able to receive communion in their rooms if they wished. At the time of inspection all residents were from the Roman Catholic faith. However, the person in charge described how she would facilitate ministers from other faiths to visit the centre if this was required.

Residents who wished to vote in elections were supported. The local polling station was close to the centre and staff stated that the person in charge arranged lifts to the polling station for residents who wanted to vote.

While there was informal consultation with residents on the running of the centre it was not organised. Inspectors were concerned to note that the resident's forum was no longer active within the centre. There was no other formal system, such as the use of an advocacy service, to consult with the residents on how the centre should be run and to allow residents to discuss their views and make suggestions.

Inspectors saw that residents had access to a range of information. Newspapers were available in the common rooms and some residents had the newspaper delivered directly to their rooms each morning. There was a well stocked library. All bedrooms were provided with a telephone and a television.

Residents' independence was promoted by staff. Residents who were mobile were facilitated to visit friends and family outside the centre and inspectors saw a number of residents leaving the centre to do this. Residents were encouraged to eat their meals independently and were given plenty time to enjoy their food. Inspectors found that residents had flexibility in their daily routines and residents said they could decide when to get up and go to bed and whether to participate in activities available to them.

There was an open visiting policy and contact with family members was encouraged. There were two comfortable rooms were residents could spend time with visitors in private.

Inspectors found that, for the most part, residents' privacy and dignity was respected by staff. Inspectors observed staff knocking on the doors of occupied rooms and waiting for permission to enter. However, inspectors observed one incident where a bedroom door was left open while a resident was receiving personal care. Inspectors observed staff interacting with residents in a courteous manner and addressing them by their preferred names. Inspectors observed good interactions between staff and residents who chatted with each other in a comfortable way.

Outcome 12
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

References:
Regulation 7: Residents' Personal Property and Possessions
Regulation 13: Clothing
Standard 4: Privacy and Dignity
Standard 17: Autonomy and Independence

Inspection findings
Inspectors visited a number of bedrooms and found that many residents chose to personalise their rooms through the provision of pictures, photographs and furniture from their own homes. Rooms were provided with large, built-in wardrobes which provided adequate personal storage space. Locked personal storage was provided where the resident requested this.

Inspectors visited the laundry and noted that there was adequate space to segregate clean and soiled clothes. Clothing items were clearly marked with the name of the resident. Inspectors spoke to staff in the laundry and found that they were knowledgeable about the systems in place to segregate laundry and prevent the spread of infection.

Inspectors asked residents and relative if they were satisfied with the way in which their clothes were cared for and all responded that they were happy with the service.

5. Suitable staffing

Outcome 13
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

References:
Regulation 15: Person in Charge
Standard 27: Operational Management

Inspection findings
Inspectors found that the arrangements for person in charge met the requirements in the Regulations. The post was full time and filled by a registered nurse who had the required experience in the area of nursing of older people and a post graduate certificate in palliative care. Since the last inspection she had also attended mandatory training in fire, elder abuse and manual handling. In addition to this she had attended training on infection control, cardio pulmonary resuscitation and subcutaneous infusion. Inspectors noted that a number of residents and relatives spoke highly of her and stated that she was routinely available to them in the centre. Adequate deputising arrangements were in place.

Outcome 14
There are appropriate staff numbers and skill-mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

References:
Regulation 16: Staffing
Regulation 17: Training and Staff Development
Regulation 18: Recruitment
Regulation 34: Volunteers
Standard 22: Recruitment
Standard 23: Staffing Levels and Qualifications
Standard 24: Training and Supervision

Inspection findings

Inspectors reviewed the staffing levels and skill-mix in the centre. The previous inspection indentified that there was inadequate staffing levels at night. The person in charge told inspectors that staffing levels were based on the assessed needs of residents, using an evidence-based tool. She stated that following recent changes in the dependency levels of four residents a consultation process was held with the residents and families involved. An agreement was made that the person in charge would recruit four new special staff to provide one-to-one supervision and the cost of this would be borne directly by the residents involved. Inspectors spoke to the next of kin of one these residents and noted that they were very satisfied with this arrangement and felt that it provided additional care as well as company for their loved one. Inspectors believed that while this system met the needs of these residents it was not a sustainable model of staff recruitment in order to address future changes in dependency levels.

Inspectors noted that the staffing levels which were provided at night did not reflect the information which had been provided to the Authority following the last inspection. The information provided indicated that the additional staff member who had been allocated to the “twilight” shift was a registered nurse. However, the person in charge stated that a care assistant now covered this shift. Inspectors were not satisfied that this arrangement adequately met the needs of residents during this time, given the dependency levels and the layout of the building. One resident commented to inspectors that there was frequently a long wait for medications at night.

Inspectors reviewed the policy on the recruitment, selection and vetting of staff and a number of staff files. The policy was in line with the Regulations. Inspectors noted that there was a very low turnover of staff and many members had worked in the centre for a number of years. All staff spoken to said that they enjoyed working in the centre and that they felt supported in their roles.

Inspectors reviewed a sample of staff files. The provider had not ensured that the required recruitment documentation had been acquired for the four new special staff including three references, photographic identification and evidence of physical and mental fitness. Evidence of Garda Síochána vetting was also absent for these staff although the person in charge stated that she had applied for this and it was pending. Inspectors were told that these staff had been working in the centre for three months.

Inspectors reviewed the staff files of two other long serving staff and found that not all of the required documentation was in place. One of these staff members, who was a registered nurse, did not have evidence of Garda Síochána vetting and a reference from the previous employer. The other staff member did not have official proof of identity and only two out of the required three references was present.

Inspectors requested information with regard to the professional registration status of all nursing staff and found that all had up-to-date registration with An Bord Altranais for 2012.

There was two volunteer staff. The person in charge stated that these staff helped at the reception desk on ground floor only. However, staff files were not maintained for these volunteers and there was no written record of their roles and responsibilities in the designated centre.

The inspectors were concerned that the delivery of health care was not adequately supervised by the person in charge. As discussed in Outcome 7, there were a number of issues which the person in charge should have been monitoring more closely including the management of nutrition, the use of restraint and the measures in place to supervise residents.

Records indicated that the staff had a received a variety of training since the last inspection. For example, some staff had received training in medication management, subcutaneous infusion, dementia care, pain management and infection control. Training in nutrition and medication management was also scheduled for 2012.

The person in charge organised monthly staff meetings for the nursing staff. Inspectors reviewed the minutes of these meetings and found that they were used to discuss pertinent issues such as hydration of residents with dementia, infection control, care planning and the checking of call bells. The person in charge stated that she held monthly meetings with the care assistants and the household staff separately but minutes were not recorded for these.

6. Safe and suitable premises

Outcome 15
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Inspection findings

The previous inspection of this centre found that the building had been extensively refurbished in order to meet the needs of the residents. On this inspection, it was observed that the building continued to be maintained to a satisfactory standard and there was a homely atmosphere. Bedrooms were suitably and comfortably furnished. A satisfactory standard of hygiene was maintained. However, inspectors were concerned to note that while bedrooms were vacuumed on a daily basis they were only cleaned and disinfected on alternative days. Inspectors did not believe that this was sufficient given that some residents were toileted in their rooms and also ate in their rooms.

Residents had access to a large and bright communal room which had views of the garden. The garden was maintained to a high standard and was provided with some garden furniture. Residents could also access the library and the large oratory on the second floor. The large dining room was spacious enough to accommodate residents from the centre and the adjacent independent living units comfortably.

Inspectors noted some poor storage patterns in the building. For example, there was a large number of chairs stacked in the day room which took up a large amount of space. These chairs were not suitable for the majority of residents as they were hard chairs without arm rests. Inspectors also noted that a number of commodes were stored in one of the assisted bathrooms on the second floor.

Inspectors noted a lack of appropriate seating in the communal room. There was a lack of general supportive, comfortable seating with sufficient arm and back rests. Inspectors observed the day room and noted that a number of residents were seated in wheelchairs which were suitable for transfer only. Inspectors were concerned that some of these wheelchairs did not have suitable foot rests and were not suitable for seating for prolonged periods.

There were records to show that assistive equipment such as hoists, baths and pressure relieving mattresses had been serviced regularly. There were also records to show that the lift had been routinely serviced.

All rooms were provided with a call bell to enable residents to summon assistance when they required. The maintenance person confirmed that he carried out regular checks on this system.

7. Records and documentation to kept at a designated centre

Outcome 16

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

References:

Part 6: The records to be kept in a designated centre
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

Inspection findings

The person in charge had developed a range of operational policies and procedures. Inspectors viewed a sample of these policies found that most were informative. However, as outlined in Outcome 7, the policy on restraint had not been maintained up to date and the policy on health and safety had not been implemented.

The centre also had a policy on the management and retention of residents' records. This policy did not provide for the retention of residents' records for a period of seven years after the resident ceased to reside at the centre. However, the administrator stated that, in practice, all records were retained for this period.

Inspectors had concerns about one aspect of the management of residents' records. When interviewing staff about wound management, some staff stated that they took pictures of the wounds using their camera phones in order to monitor the progress of the wounds. The person in charge stated that she was aware of this process. Staff stated that they asked the residents permission before doing this. After discussing this matter the person in charge stated that she would address it immediately and ensure the security of residents' personal records.

The person in charge and the provider had developed a Residents' Guide on line with the Regulations. It provided information to residents such as summary of the statement of purpose and an overview of the complaints procedure.

There were systems in place to record the care given to residents. However, inspectors noted that these systems could have been improved. For example, the care assistants did not record the care which they gave to residents. Instead they verbally communicated this information to the nursing staff who were responsible for recording it in the nursing notes. However, inspectors found that this information was frequently not detailed and was often abbreviated to "care given as per care plan" or similar wording. Due to the deficits in the care planning and assessment process as described earlier in this report this was not an adequate record of the daily care and treatment given to residents.

Inspectors examined the directory of residents and found that it was maintained up to date and contained the information prescribed by the Regulations.

The provider had an up-to-date insurance policy which was dated 12 January 2012 and provided satisfactory insurance cover for the service and residents' individual belongings.

Outcome 17
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

References:
Regulation 36: Notification of Incidents
Standard 29: Management Systems
Standard 30: Quality Assurance and Continuous Improvement
Standard 32: Register and Residents' Records

Inspection findings
Inspectors reviewed the accidents and incident records. In general, details of each accident/incident, observation and treatment, and the follow up action taken were appropriately recorded Inspectors saw that the resident's GP and next of kin were routinely notified if an incident occurred. However, inspectors did note some incidents where complete details were not recorded. Details regarding whether the fall was witnessed or unwitnessed was not routine recorded. Inspectors believed the inclusion of this information would enable better analysis and review.

Staff spoken to were knowledgeable with regard to the legal requirement to notify the Chief Inspector of those incidents and accidents prescribed in the Regulations. Inspectors did not identify any incident which the person in charge had failed to notify the authority about.

Outcome 18
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

References:
Regulation 37: Notification of periods when the Person in Charge is absent from a Designated Centre
Regulation 38: Notification of the procedures and arrangements for periods when the person in charge is absent from a Designated Centre
Standard 27: Operational Management

Inspection finding
The provider was aware of the requirement to notify the Chief Inspector if the person in charge was to be absent for an extended period.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider, 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 co-operation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:

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Social Services Inspectorate
Health Information and Quality Authority

17 July 2012

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report*

Centre:	Queen of Peace Centre
Centre ID:	0085
Date of inspection:	10 and 11 July 2012
Date of response:	21 August 2012

Requirements

These requirements set out the actions that must be taken to meet 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*.

Outcome 1: Statement of purpose and quality management

1. The provider is failing to comply with a regulatory requirement in the following respect: The statement of purpose did not address all of the matters in Schedule 1 of the Regulations.
Action required: Compile a statement of purpose that consists of all matters listed in Schedule 1 of the Regulations.
Action required: Make a copy of the statement of purpose available to the Chief Inspector

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

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: Statement of purpose has been updated to reflect all matters listed in Schedule 1. A copy had been sent to the Chief Inspector.	Completed

Outcome 2: Reviewing and improving the quality and safety of care

2. The provider is failing to comply with a regulatory requirement in the following respect: There was no formal system in place to ensure that the quality of care given to residents was monitored, developed and improved on an ongoing basis.	
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 full review and audit of all services provided to the residents is currently under way, including a full review of care files, medication management, falls assessment and nutritional review in order that all findings are noted and this ensures that change will take place. A full consultation process for the residents and their representatives will take place over the coming weeks. A residents committee is being formed and a number of family members have indicated their willingness to participate. This process will enable the identification of any changes to the quality and safety of care provided, thereby enhancing the quality of life of the residents.	28/09/2012 First meeting 29/08/2012 monthly thereafter

Outcome 3: Complaints procedures

3. The provider is failing to comply with a regulatory requirement in the following respect: The details of the investigation carried out, was not recorded for all complaints which were received. A record of the satisfaction rating of the complainant with the outcome of a complaint investigation was not maintained.
Action required: Record all complaints and the results of any investigations into the matters complained about. Ensure these records are in addition to and distinct from a resident's individual care plan.
Action required: Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.
Reference: Health Act, 2007 Regulation 39: Complaints Procedures Standard 6: Complaints

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A more robust method of recording complaints into the complaints log in now in place. All information regarding the investigation of any complaint will be recorded outside the care plan. All future complaints will be documented and the satisfaction level of the complainant together with the outcome will be recorded.	10/08/2012

Outcome 4: Safeguarding and safety

4. The provider and person in charge is failing to comply with a regulatory requirement in the following respect: The policy on elder abuse did not guide the procedure for responding to allegations of elder abuse. One staff member did not know or understand the correct procedures to follow in relation to the protection of vulnerable adults.

The person in charge and the ADON could not describe, in detail, the process for investigating an allegation of abuse.

Four staff members had not been trained in the procedures for the protection of residents from 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.

Action Required:

Put in place a policy on and procedures for the prevention, detection and response to abuse.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Standard 8: Protection

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
The policy on Prevention, Detection and Response to Elder Abuse has been revised.	Completed 10/08/2012
A Flow Diagram on how to report allegations of elder abuse has been included and disseminated to all staff members.	10/08/2012
Staff members including the four staff members identified in the report will be receiving further training regarding their role and responsibility in reporting and dealing with any disclosure of suspected or actual episodes of elder abuse.	31/08/2012

Outcome 5: Health and safety and risk management

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

The risk management policy was not implemented.

Vulnerable residents had direct access to the stairwells, to the exterior of the building and to two open verandas.

No risk assessment or control measures had been put in place to protect a resident who smoked in bed.

The provider was required to take immediate action in relation to access to the stairwells, access to the exterior of the building and the smoking issue.

Some of the wheelchairs which were used to transfer residents did not protect the residents from the risk of injury while being transferred.

The emergency plan had not been updated to guide staff in the event of an emergency.

The emergency lighting system was not serviced since 2010.

Fire drills were not documented.

Not all staff had attended fire safety training.

Combustible materials were stored on the fire exit.

Action required:

Put in place a comprehensive written risk management policy and implement this throughout the designated centre.

Action required:

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

Action Required

Put in place an emergency plan for responding to emergencies.

Action Required

Make adequate arrangements for reviewing fire precautions, and testing fire equipment, at suitable intervals.

Action Required

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

Action Required

Provide suitable training for staff in fire prevention.

Action Required Provide adequate means of escape in the event of fire.	
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety Standard 29: Management Systems 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:	
An electronic door control system will be installed on all doors leading to stairwells and external doors, a system has been tested on site and an instruction to install same has been given to the electrical contractor.	To be completed by 31/08/2012
A full review of access to verandas and the external parts of the centre is taking place and a plan to secure the grounds of the designated centre is being put in place. Access to the verandas has ceased and doors locked to these areas, while a design process has been completed and tenders due this week to provide a 1.8m high glazed screen in these locations.	To be completed by 07/09/2012
A design process has been completed to provide a new fence dividing the nursing home resident's garden and the independent living units, thereby creating a fully secure garden to the rear of the facility. Work is due to commence on this element within one week. In the interim, residents are permitted in the garden area when supervised by care staff.	To be completed by 07/09/2012
The Risk Management policy is being reviewed and a full risk management audit is taking place. Any changes to the policy will reflect the outcome of the risk management audit.	To be completed by 07/09/2012
A Health and Safety committee has been established that will monitor the ongoing identification and management of risks inside and outside the centre.	Completed 10/08/2012
The emergency plan has been updated to reflect the evacuation site and how to deal with an emergency should any arise.	Completed 10/08/2012
The emergency lights have been tested and the outcome recorded in fire book.	Completed 10/08/2012

All fire escapes have been identified and directional maps are due for erection on site this week. A review of fire assembly points and fire training will take place this week.	Completed 17/08/2012
All fire escape pathways, stairwells etc are clear of obstructions. Fire blankets are fitted to all the resident's beds.	Completed 10/08/2012
A review of the smoking policy has taken place and is implemented. A smoking apron has been provided for the resident's use, staff have been instructed that resident's cannot smoke in their rooms and must be transferred to the external covered area on the ground floor to smoke and be kept under observation during this activity.	Completed 10-8-2012
Occupational Therapy seating assessment has commenced for our residents. To be completed by 31 August 2012.	31/08/2012
An ongoing review of wheelchairs is taking place. Footrests will be provided for wheelchairs as assessed.	29/08/2012
Fire and evacuation training has been arranged for all members of staff over the next 10 days. First training session completed on 14 August 2012, second arranged for 24 August 2012.	14/08/2012 24/08/2012

Outcome 6: Medication management

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

The medication management policy was not implemented in relation to the use of PRN psychotropic medications.

The maximum dose in 24 hours of some PRN medications was not prescribed.

Crushed medications were not prescribed by the GP.

Action required:

Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

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: The policy on Psychotropic Drug Use had been reviewed and discussed during nurses meeting last 30 July 2012. Nurses had been instructed on the use the ABC chart for residents with behaviours that challenge as a method of recording such behaviour. Thereby providing an insight as to how and why the behaviour was exhibited. The nursing staff have received education on the use of Psychotropic medications and that such medications should only be given as the last option when all the non-pharmacological interventions fail to have the desired effect. The maximum dose in 24 hours of as required medications is now recorded on the medication kardex and signed by the GP. The GP prescribed and signed the medication that needs to be crushed.	Completed 10/08/2012 10/082012 10/08/2012

Outcome 7: Health and social care needs

7. The person in charge is failing to comply with a regulatory requirement in the following respect:

A high standard of evidenced based nursing practice was not evident in the following areas:

- nutritional care
- supervision of residents
- restraint management.

The provider was required to take immediate action in relation to supervision of residents and nutritional management.

Assessments and plans of care did not identify and address the needs of some residents in order to guide care.

Action Required:

Put in place suitable and sufficient care to maintain each resident's welfare and wellbeing.

Action required:

Provide a high standard of evidence-based nursing practice.

Action Required: Set out each resident's needs in an individual care plan developed and agreed with the resident.	
Action Required: Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 13: Healthcare Standard 18: Routines and Expectations Regulation 8: Assessment and Care Plan Standard 3: Consent Standard 10: Assessment Standard 11: The Resident's Care Plan Standard 17: Autonomy and Independence	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A nutritional care lecture/training completed on 26 and 27 July 2012. A Dietician came last 17 and 31 July 2012 to review all residents who had lost weight recently and those with MUST Score of 1 to 2. The Dietician will come back after three months for review. There is an ongoing review of all the care plans and risk assessments which will address all the identified residents needs and will guide the staff to deliver care at the highest level. Risk management to be completed. Training on the use of restraint will be taking place over the next three weeks for the nursing and care staff. A programme for CPD training for all the nursing staff is being prepared to ensure the highest level of care is provided for the residents at all times. A Pool Activity Level Profile will be carried out for all the residents to identify each resident's interests and capabilities in order that every effort will be made to provide opportunity for the residents to participate as far as they are able to in activities.	Completed To be completed by 14/09/2012 07/09/2012 07/09/2012 28/09/2012 07/09/2012

Outcome 11: Residents' rights, dignity and consultation

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

Arrangements were not in place for the consultation of residents on the organisation of the designated centre.

Action required:

Put in place arrangements to facilitate residents' consultation and participation in the organisation of the designated centre.

Reference:

Health Act, 2007
Regulation 10: Residents' Rights, Dignity and Consultation
Standard 2: Consultation and Participation

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A new resident's and relatives committee will be established over the coming weeks. It is hoped that this committee will offer the residents and their relatives an opportunity to become involved in the care experiences of the residents residing in the centre.	29/08/2012

Outcome 14: Suitable staffing

9. The provider and person in charge are failing to comply with a regulatory requirement in the following respect:

Staffing levels at night were not adequate.

Some staff files did not contain all the information required in Schedule 2 of the Regulations.

The person in charge did not consistently supervise the care which was delivered by staff.

Volunteer staff did not have written agreements setting out their roles and responsibilities.

Action required:

Ensure that the numbers and skill-mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

Action Required:

Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 of the Regulations have been obtained in respect of each person.

Action Required:

Supervise all staff members on an appropriate basis pertinent to their role.

Action Required:

Ensure volunteers working in the designated centre are vetted appropriate to their role and level of involvement in the designated centre.

Reference:

Health Act 2007
Regulation 16: Staffing
Standard 23: Staffing Levels and Qualifications
Regulation 17: Training and Staff Development
Standard 24: Training and Supervision
Regulation 34: Volunteers
Standard 22: Recruitment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
An extra care staff member has been deployed on night duty. This staff member will be working a full night shift, 12 hours, and is additional to the previous roster.	Completed 10/08/2012
All staff files are being reviewed with regard to Schedule 2 requirements. Staff members with incomplete files have been requested to provide the necessary documentation within a two week timeframe.	31/082012
The staff supervision has been enhanced to ensure all those employed in the centre are aware of their roles and responsibilities in providing the highest standards of care for the residents. This role will be carried out by the person in charge and her deputies.	31/08/2012
Volunteers will be provided with their role description and asked to provide the relevant information associated with their roles as volunteers in a designated centre within a two week time frame.	31/08/2012

Outcome 15: Safe and suitable premises

10. The provider is failing to comply with a regulatory requirement in the following respect: Suitable storage was not provided for commodes and for seating. There was an insufficient number of appropriate chairs in the day room.
Action required: Make suitable provision is made for storage in the designated centre
Action Required: Make suitable adaptations, and provide such support, equipment and facilities, including passenger lifts for residents, as may be required.
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:	
We are currently identifying suitable storage areas on each floor for the commodes and extra seating.	31/08/2012
Extra appropriate seating and equipment will be provided for the residents after the occupational therapy seating assessments which commenced on 15 August 2012.	28/09/2012
A full servicing programme has been developed for all equipment utilised in the centre.	31/08/2012

Outcome 16: Records and documentation to be kept at a designated centre

11. The provider is failing to comply with a regulatory requirement in the following respect: Photographic records of wounds were inappropriately stored. The policy on restraint had not been reviewed to incorporate pertinent national guidance.

Action required: Complete, and maintain in a safe and accessible place, an adequate nursing record of each resident's health and condition and treatment given, on a daily basis, signed and dated by the nurse on duty in accordance with any relevant professional guidelines.	
Action required: Review all the written operational policies and procedures of the designated centre on the recommendation of the Chief Inspector and at least every three years.	
Reference: Health Act, 2007 Regulation 27: Operating Policies and Procedures Regulation 25: Medical Records Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Staff have been instructed that the use of personal mobile cameras in not permitted to record any of residents. Queen of Peace had provided an official camera to be used with the residents' consent. Restraint policy is under reviewed and will be updated to reflect recently published national policy on restraint. All operational policies and procedures will be reviewed on at least a two yearly basis and as new legislation indicates. All nursing documentation will be correctly maintained according to professional guidelines and CPD updates and reviewed on a three-monthly basis.	Completed 10/8/2012 31/08/2012

Any comments the provider may wish to make:

Provider's response:

We in Queen of Peace Centre will continue to strive to meet the growing care needs of our residents. We will to continue to ensure that all the necessary actions required by us will be implemented to ensure the best outcomes for our residents at all times.

Provider's name: Sr. Rose Nuval
Date: 21 August 2012