Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection Report
Designated Centres under Health Act 2007, as amended

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:	01 497 5381
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:	Helen Mullery
Date of inspection:	2 July 2013
Time inspection took place:	**Start:** 10:00 hrs **Completion:** 18:30 hrs
Lead inspector:	Gary Kiernan
Support inspector(s):	N/A
Type of inspection	☒ **announced** ☐ **unannounced**
Number of residents on the date of inspection:	43 + 1 in Hospital
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

Regulation has two aspects:

- Registration: under section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of their registration.

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Summary of 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*.

This inspection report sets out the findings of a monitoring inspection, in which 10 of the 18 outcomes were inspected against. The purpose of the inspection was:

- ☐ to inform a registration decision
- ☐ to inform a registration renewal decision
- ☒ to monitor ongoing compliance with Regulations and Standards
- ☐ following an application to vary registration conditions
- ☐ following a notification of a significant incident or event
- ☒ following a notification of a change in person in charge
- ☐ following information received in relation to a concern/complaint

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

Outcome 1: Statement of Purpose	☒
Outcome 2: Contract for the Provision of Services	☐
Outcome 3: Suitable Person in Charge	☒
Outcome 4: Records and documentation to be kept at a designated centres	☐
Outcome 5: Absence of the person in charge	☐
Outcome 6: Safeguarding and Safety	☒
Outcome 7: Health and Safety and Risk Management	☒
Outcome 8: Medication Management	☒
Outcome 9: Notification of Incidents	☐
Outcome 10: Reviewing and improving the quality and safety of care	☒
Outcome 11: Health and Social Care Needs	☒
Outcome 12: Safe and Suitable Premises	☐
Outcome 13: Complaints procedures	☒
Outcome 14: End of Life Care	☐
Outcome 15: Food and Nutrition	☐
Outcome 16: Residents' Rights, Dignity and Consultation	☒
Outcome 17: Residents' clothing and personal property and possessions	☐
Outcome 18: Suitable Staffing	☒

This monitoring inspection was announced and took place over one day. As part of the monitoring inspection the inspector met with residents, relatives, and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

The inspector followed up on the areas of risk identified at the previous inspection and found improvements in all of these areas. While areas for further improvement were identified, overall the inspector found an increased level of compliance with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated

Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland.*

Improved arrangements were in place for the management of health and safety issues. However, the risk management policy did not meet the requirements of the Regulations and was not guiding practice in this area. Improvements were also required with regard to fire safety training and the checking of the emergency lighting system.

Residents' healthcare needs appeared to be met and residents had good access to the general practitioner (GP) and allied health professionals. However, some improvements were required in the management of falls, behaviours that challenged and restraint. Care plans were not in place for all residents' identified needs and the arrangements for consultation with residents on the development of their care plans were not satisfactory. The skill mix of staff in the late evening required review.

There was an effective system in place for reviewing the quality and safety of care. Residents were consulted about the operation of the centre and were listened to. The provision of activities for residents had been developed and expanded and this enhanced the quality of residents' lives.

These issues are further discussed in the body of the report and in the Action Plan at the end of the report.

Section 41(1)(c) of the Health Act 2007

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*.

Theme: Leadership, Governance and Management

Effective governance, leadership and management, in keeping with the size and complexity of the service, are fundamental prerequisites for the sustainable delivery of safe, effective person-centred care and support.

Outcome 1

There is a written statement of purpose that accurately describes the service 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

Action(s) required from previous inspection:

Compile a statement of purpose that consists of all matters listed in Schedule 1 of the Regulations.

Inspection findings

The statement of purpose had been revised since the previous inspection; however, it still required some additional information in order to fully comply with the requirements of the Regulations.

The inspector 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 revised since the previous inspection. However, the correct number of residents who may be accommodated was not stated and the document referred to the former person in charge in a number of instances. The summary of the complaints procedure was not accurate and the conditions of registration were not included.

Outcome 3
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

Action(s) required from previous inspection:

The action required from the previous inspection was satisfactorily implemented.

Inspection findings

The arrangements for the post of person in charge met the requirements of the Regulations.

The previous inspection found that the post of person in charge was held by a person who no longer wished to continue in that position and steps had not been taken to appropriately manage the situation. The inspector found that this matter had been addressed.

Helen Mullery commenced in the role of person in charge on 19 March 2013 and had previously been the person in charge in another designated centre. A fit person interview was held with the person in charge during this inspection where she demonstrated a satisfactory knowledge of the Regulations and the Authority's Standards. The person in charge was a registered general nurse, had the relevant necessary experience and worked full-time in the centre. She demonstrated a good understanding of her role and responsibilities as outlined in the Regulations and also demonstrated a commitment to improving the service for residents. Since commencing in her new role she had taken time to get to know the residents and was knowledgeable about their care needs. She had established a strong residents' forum and residents stated that she listened to their views. She had held a number of staff meetings to introduce herself. Staff in the centre spoke highly of the new person in charge and stated that she was supportive of them.

The person in charge held post graduate qualifications in business management and in gerontology. She had maintained her continued professional development and had attended a number of short courses in relevant clinical areas such as clinical auditing, medication management, infection control and risk management. She had also recently completed a 'Train the Trainer' course in the area of protection of vulnerable adults from elder abuse.

She was supported in her role by the assistant director of nursing (ADON) who deputised in the absence of the person in charge. The ADON was not present during this inspection. Support was also provided by the clinical nurse manager (CNM). The CNM was present throughout the inspection, participated fully in the inspection process and demonstrated a strong knowledge of her roles and responsibilities under the Regulations.

Theme: Safe care and support
Safe care and support recognises that the safety of service users is paramount. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers.

In a safe service, a focus on quality and safety improvement becomes part of a service-wide culture and is embedded in the service's daily practices and processes rather than being viewed or undertaken as a separate activity.

To achieve a culture of quality and safety everyone in the service has a responsibility to identify and manage risk and use evidence-based decision-making to maximise the safety outcomes for service users.

Outcome 6
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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspector found that measures were in place to protect residents from being harmed.

A policy was available which gave guidance to staff on the assessment, reporting and investigation of any allegation of abuse. The person in charge and all staff spoken with displayed sufficient knowledge of the different forms of elder abuse and all were

clear on reporting procedures and their responsibilities as described in the policy. All residents spoken with said that they felt safe and secure in the centre. The training records showed that one part-time staff member had not attended training on identifying and responding to elder abuse, in accordance with the centre's policy. The person in charge was aware of this and had a plan in place to address this matter. The person in charge had recently completed the 'Train the Trainer' course on the protection of vulnerable adults from abuse and she was planning to provide this training for all staff on an annual basis.

The person in charge stated that the majority of residents managed their own finances. The inspector reviewed the systems in place for safe guarding residents' money at the previous inspection and found that they were satisfactory. Therefore these systems were not re-examined on this inspection.

Outcome 7
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

Action(s) required from previous inspection:

Provide suitable training for staff in fire prevention.

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

Inspection findings

A number of improvements had been made to promote the health and safety of residents since the previous inspection. However, some further improvements were required in the area of fire safety and in the risk management policy.

The previous inspection identified a number of areas of risk, which included fire safety, exposed hot radiator surfaces, moving and handling and access to a secure outdoor area. The inspector found that improvements had been made in all of these areas as follows:

- the fire safety panel had been upgraded and was subject to regular in-house checks and checks by an external consultant. The inspector saw that locked fire exits now opened immediately upon activation of the fire alarm. There was also an in-house check on the effective operation of self closing fire doors
- a personal evacuation plan had been developed for each resident

- the heating system had been upgraded and modernised to allow for the safe control of radiator temperatures. In addition to this there was a daily check on radiator surface temperatures in every bedroom which was signed and dated
- staff had up-to-date training in moving and handling and resident's moving and handling needs were individually assessed and instructions were drawn up
- a secure outdoor garden was provided for residents
- risk assessment training had been provided for a number of key staff.

There was a safety statement in place and this document had been reviewed and updated since the previous inspection with the aid of a health and safety consultant. There was also a risk register in place which recorded the identified risks for the centre and the associated control measures. The inspector noted that the person in charge was also carrying out risk assessments where issues of risk were identified on an ongoing basis. There was a centre-specific risk management policy in place; however, the policy did not address all the risks specified in the Regulations, such as self harm and violence. The person in charge had implemented procedures for the ongoing identification and management of risks in the centre. These included the establishment of a health and safety committee, which met regularly and the carrying out of health and safety audits. However, the risk management policy did not describe these practices or guide practice in this area.

The inspector reviewed the fire safety procedures and found that while there was a system of fire safety checks in place, five members of staff did not have up-to-date mandatory training in fire safety. The inspector spoke with a number of staff who were able to describe the correct procedure to follow in the event of a fire. The records showed that the fire equipment including fire detection and alarm system and fire fighting equipment were regularly serviced by an external consultant. However, the emergency lighting system was subject to an annual check and the provider could not demonstrate that this was an appropriate frequency for servicing this equipment. The daily in-house check of all escape routes was documented. A weekly in-house check of the fire alarm system was also in place.

The centre had an emergency plan in place which provided information to guide staff on the procedures to follow in the event of the evacuation of the centre. The plan also provided details of alternative accommodation and transport in the event that an emergency evacuation was required. However, the plan did not address issues such as the loss of heat, power or water supply.

The inspector found that there was a serious of routine safety checks on aspects such as hot water, call bells and equipment which was carried out and documented by the maintenance person on a weekly basis.

The inspector found that systems were in place to learn from accidents, incidents and near misses which were recorded in detail. The records detailed the action taken and the treatment given where this was required. The person in charge reviewed each individual incident and the minutes of staff meetings showed that incidents were discussed with staff to promote learning.

The training matrix showed that staff had up-to-date training in moving and handling. Residents' moving and handling assessments were routinely assessed and instructions for assisting residents to mobilise were discretely displayed in a location where staff could easily access them.

There were no residents who smoked at the time of inspection. The person in charge displayed an awareness of the need to risk assess this activity and to put the appropriate controls in place as the need arose.

Outcome 8
Each resident is protected by the designated centres' policies and procedures for medication management.

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

Action(s) required from previous inspection:

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.

Inspection findings

The previous inspection found that medication management audits were not being carried out in accordance with the centre's procedures. The inspector found that this matter had been addressed. Monthly medication audits were being carried out by the CNM and she discussed positive improvements which had been made as a result of these audits such as the date labelling of bulk medications and better systems for ordering medications.

For the most part, there was evidence of good practice in relation to medication management however, practice in relation to the management of medication errors required improvement.

The inspector noted that a small number of medication errors were recorded. These incidents were recorded in detail and the GP was informed where appropriate. The records showed that steps were taken to ensure the safety of the resident. However, in the case of the most recent error, the error form was not fully completed to include the learning outcomes and actions taken to prevent further reoccurrence. There was no evidence that the matter was discussed with the wider staff in order to promote learning. The inspector found that this did not facilitate review and learning following an incident.

A comprehensive policy was in place which guided practice. The inspector read completed prescription and administration records and saw that they were in line with professional guidelines. Written evidence was available that three-monthly reviews were carried out by the GP and in conjunction with the pharmacist.

Medications that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with the Misuse of Drugs (Safe Custody) Regulations, 1984. Nurses kept a register of MDAs. The stock balance was checked and signed by two nurses at the change of each shift. The inspector checked the balances and found them to be correct.

All staff nurses were required to undertake an e-learning programme in medication management. The inspector noted from the training records that nursing staff had completed this training and one recently recruited nurse was due to complete it.

A medication fridge was available in a locked room in each unit and the inspector noted that the temperatures were recorded daily and were within accepted limits. There were appropriate procedures for the handling and disposal of unused and out of date medicines.

The medication policy provided guidance to staff on the management of residents who wished to self-medicate. There were no residents availing of this at the time of inspection.

Theme: Effective care and support

The fundamental principle of effective care and support is that it consistently delivers the best achievable outcomes for people using a service within the context of that service and resources available to it. This is achieved by using best available national and international evidence and ongoing evaluation of service-user outcomes to determine the effectiveness of the design and delivery of care and support. How this care and support is designed and delivered should meet service users' assessed needs in a timely manner, while balancing the needs of other service users.

Outcome 10

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

Action(s) required from previous inspection:

The action required from the previous inspection was satisfactorily implemented.

Inspection findings

The person in charge had systems in place to monitor and review the quality and safety of care on an ongoing basis.

The person in charge had put a system in place to gather and review information on a monthly basis relating to areas of risk such as nutritional status, falls, incidence of pressure ulcers and the use of restraint. This clinical data was used to identify possible trends and alert the person in charge to residents who were at an increased risk, for example, residents who had repeated falls or residents who had significant weight loss. Learning outcomes and targeted interventions for residents were reviewed and discussed at weekly staff meetings.

There was a schedule of audits in place for 2013. To date a number of audits had been carried out in areas such as nutrition, moving and handling, medication management, accidents and incidents and hand hygiene. The inspector saw that in general high levels of compliance were recorded and where issues were identified, they were promptly remedied. For example, the inspector saw that in response to the moving and handling audit the person in charge had organised additional training for the staff on this subject. A survey of residents and relatives was carried out in March 2013. The results of this survey were analysed by the person in charge and highlighted issues in relation to the provision of activities. The person in charge took action in relation to these findings and as a result the provision of activities for residents was developed and improved as covered further under Outcome 11 below.

Outcome 11
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each 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

Action(s) required from previous inspection:

Provide a high standard of evidence-based nursing practice.

Set out each resident's needs in an individual care plan developed and agreed with the resident.

Inspection findings

The previous inspection found that a varied schedule of activities had not been provided for residents. The inspector found this area had been greatly improved and developed. Activities included singing, flower arranging, baking, exercise classes, pet therapy and Sonas (a therapeutic technique based on communication for residents with a cognitive impairment). Residents were encouraged to be independent and some went outside for walks or used the garden which was large and had been made secure. Social assessments were carried out with all residents and care plans for social interaction had been drawn up. Additional training in activities had been provided for some staff members and residents stated they were satisfied with the range of activities available. Residents who were confused or who had dementia-related conditions were encouraged to participate in the activities. A range of one-on-one activities were provided for residents who did not wish to participate in the group setting. The person in charge was also in the process of organising a number of outings for residents based on their feedback.

While there was evidence of good practice in some areas of healthcare, a number of improvements were required in the area of falls, behaviours that challenge and the management of restraint. Improvements in care planning were also identified.

At the time of inspection a computerised system of care planning and clinical documentation was being introduced. The inspector found that the system was being introduced on a phased basis and staff had been provided with appropriate training. The inspector reviewed a sample of residents' care plans and found that relevant risk assessments such as skin integrity, continence, falls and nutrition were routinely carried out.

In general residents had care plans in place for their identified needs, however, a number of the care plans were not person-centred and had been drawn up using generic phrases, some of which were not relevant to the resident. There was inconsistent evidence of resident or next of kin involvement in the care planning process.

Residents' falls risk was assessed after admission and routinely thereafter. Residents at a high risk of falls had been provided with a range of interventions to reduce this risk of injury and these included low beds, crash mats and increased supervision arrangements where appropriate. The inspector reviewed the records of a resident who had a history of falls and found that improvements were required. The inspector saw that following a fall, a falls diary was completed. However, the care plan was not updated following the most recent fall and there was no evidence that a review of

current risk reduction measures took place as required by the centre's fall management policy. As a result the inspector found that all relevant additional preventive measures had not been considered or trialled. Neurological observations were not always carried in the event of any un-witnessed fall or possible injury to the head.

Improvements were required in the management of restraint. There was a policy in place to guide practice in this area. However, the policy was not being adhered to as two different restraint assessment tools were in use and one of these risk assessment tools did not consider the risks associated with the use of restraint. The restraint assessments did not consistently demonstrate consultation with the resident or next of kin prior to a decision to use restraint. The inspector also found that in the case of lap belts the restraint assessment procedure was not implemented. A restraint register was in place and a record was also maintained of when restraint was used and periods of release.

The inspector found some evidence of good practice in relation to the management of behaviours that challenged, however, in the case of one resident, no care plan had been developed for this need. The inspector found that as result there was absence of guidance for staff on how to pre-empt and manage the behaviour in a way that consistently met the needs of the resident. There was good access to the psychiatry of old age team for those residents who required this. The inspector found that staff were knowledgeable about meeting the needs of residents who displayed behaviours that challenged and recent training had been provided in this area.

There was evidence of good practice in relation to the management of nutrition. Resident's weights were monitored monthly and more frequently where indicated. Residents who had lost weight were seen by the dietician and supplements were prescribed as necessary. Residents who had experienced weight loss had care plans in place which incorporated the recommendations of the dietician. A daily monitoring record of nutritional intake was also implemented where appropriate. Training had been provided for a number of staff in the area of nutrition and dysphasia.

There was a daily nursing record of each resident's condition and the medical notes showed that residents had regular access to their GP. Residents also had good access to allied health professionals when needed such as speech and language therapist (SALT), dietician, chiropodist, dentist and the psychiatry of old age team. Records of these referrals were written up in the residents' records.

Theme: Person-centred care and support
Person-centred care and support has service users at the centre of all that the service does. It does this by advocating for the needs of service users, protecting their rights, respecting their values, preferences and diversity and actively involving them in the provision of care. Person-centred care and support promotes kindness, consideration and respect for service users' dignity, privacy and autonomy.

Outcome 13
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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

There was evidence of good practice in the area of complaints management, however, the centre's policy and the complaints procedure, which was displayed, did not comply with the Regulations and did not guide practice in this area.

The complaints policy did not identify the complaints officer and did not clearly describe the appeals process. The policy also failed to identify a third independent person other than the complaints officer and the appeals officer to oversee the management of complaints. The complaints procedure was displayed in the entrance hall; however, it also failed to identify the complaints officer and did not give guidance on the appeals process.

The person in charge demonstrated a positive attitude towards complaints. The complaints log was read and the inspector found evidence of good complaints management, including a record of the complainant's level of satisfaction with the outcome of a complaint investigation.

Outcome 16
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

Action(s) required from previous inspection:

The action required from the previous inspection was satisfactorily implemented.

Inspection findings

The previous inspection found that procedures were not in place for the consultation of residents on the organisation of the centre. This matter was addressed. A residents' forum had been set up and an independent person had agreed to act as facilitator. Three meetings had already been held and an alternative room was being organised for the forthcoming meeting as attendance had been much higher than anticipated. The inspector read the minutes of the most recent meeting and saw that where issues were raised action was taken to address these matters. For example, the minutes showed that residents' preferences regarding activities had been implemented and a post box had been provided in response to residents' suggestions.

There was evidence that staff respected the resident's privacy and dignity and residents were consulted with regard to the operation of the centre.

Staff were observed knocking on bedroom, toilet and bathroom doors and waiting for permission to enter. Residents were dressed well and according to their individual choice. The inspector observed staff interacting with residents in a courteous manner and addressing them by their preferred name.

Residents could attend mass in the centre every day and religious sisters also visited a number of the residents on a pastoral basis. The person in charge said that residents from all religious denominations were supported to practice their religious beliefs and ministers from other faiths also visited the centre as appropriate.

The person in charge had made arrangements for residents to vote in local and national elections. The person in charge ensured that residents were registered to vote and maintained records in relation to this.

Residents were encouraged to maintain links with the local community. Many neighbours and friends of residents attended daily mass in the centre. Residents stated that their visitors were made feel welcome at any time. There was a library and separate sitting room where residents could meet their visitors in private. Independent living accommodation, managed by the provider, was located adjacent to the centre. A number of people who lived there joined the residents at meal times which also provided opportunities for socialising.

Theme: Workforce

The workforce providing a health and social care and support service consists of all the people who work in, for, or with the service provider and they are all integral to the delivery of a high quality, person-centred and safe service. Service providers must be able to assure the public, service users and their workforce that everyone working in the service is contributing to a high quality safe service.

Outcome 18

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

Action(s) required from previous inspection:

The action required from the previous inspection was satisfactorily implemented.

Inspection findings

The previous inspection found that a plan was not in place to address the training needs of staff. This matter had been addressed. The records showed that a range of relevant, non-mandatory training had been provided since the previous inspection and this included nutrition, falls, medication management and risk management. Staff members stated to the inspector that they were supported to attend any relevant training. A system of annual staff appraisals was also in place and the inspector saw evidence of this on the staff files.

Two volunteers were working at the centre and provided valuable services for the residents. In response to the previous inspection the person in charge had sought Garda Síochána vetting for these volunteers and there was a written agreement of roles and responsibilities in place.

The inspector found evidence on this inspection of good practice in relation to the recruitment of staff and the level of staffing however, the skill mix of staff in the late evening required review.

There was 24 hour nursing cover. Three nursing staff and eight healthcare assistants were providing care to 43 residents on the morning of inspection. However, after 19:30hrs there was only one nurse on duty. The inspector found that this level of nursing cover could compromise the care of residents during the evening medication round as during this time the remaining nurse was not free to supervise staff and the delivery of care. This matter had been highlighted as an issue in previous inspection reports and action required was undertaken by the provider. However, the inspector found that the skill mix had not been maintained in line with the residents' needs. The layout of bedrooms over two floors was also identified as an important factor for consideration. The person in charge stated that she had identified the provision of additional nursing hours in the evening as an issue. She had a plan in place to recruit additional nursing staff and reorganise shifts in order to address this matter. Residents, staff and relatives spoken with stated there were adequate numbers of staff on duty.

There was a comprehensive written operational staff recruitment policy in place. A sample of staff files was reviewed and the inspector noted that the required documentation was in place in line with the requirements of Schedule 2 of the Regulations. The inspector requested the An Bord Altranais agus Cnáimhseachais na hÉireann registration numbers for all nursing staff and found that all were in place.

Closing the visit

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

Acknowledgements

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

Report compiled by:

Gary Kiernan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

5 July 2013

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report *

Centre Name:	Queen of Peace Centre
Centre ID:	0085
Date of inspection:	2 July 2013
Date of response:	22 July 2013

Requirements

These requirements set out the actions that must be taken to meet the requirements of the Health Act 2007 as amended, 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*.

Theme: Governance, Leadership and Management

Outcome 1: Statement of purpose and quality management

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.

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

Action required: Make a copy of the statement of purpose available to the Chief Inspector
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 revised and updated and is available to the Chief Inspector.	Completed

Theme: Safe care and support

Outcome 7: Health and safety and risk management

The provider is failing to comply with a regulatory requirement in the following respect: The risk management policy did not meet the requirements of the Regulations. A number of staff did not have up-to-date training in fire safety. The provider did not demonstrate that the maintenance of the emergency lighting system was carried out at the appropriate frequency. The emergency plan did not deal with the procedures to follow in the event of loss of heat, power or water supply.
Action required: Put in place a comprehensive written risk management policy and implement this throughout the designated centre.
Action required: Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.
Action required: Provide suitable training for staff in fire prevention.

Action required: Make adequate arrangements for the maintenance of all fire equipment.	
Action required: Put in place an emergency plan for responding to emergencies.	
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Regulation 32: Fire Precautions and Records Standard 26: Health and Safety Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Action 1: The risk management policy is under review in consultation with the health and safety committee. The updated policy will be disseminated to all staff and discussed at team meetings. Risk management has been added to the fixed agenda for all team meetings. All staff are aware of their responsibility to read and acknowledge all policies relevant to their role in the Centre. Action 2: The updated risk management policy will address all risks specified in to Regulation i.e. aggression, violence, assault and self-harm. Policies, procedures and guidelines for the management of aggression, violence, assault and self harm are under review. The PPGs for the management of these areas will be further developed and included in the risk management policy. All identified risks relating to aggression, violence, assault and self harm will be added to the risk register. Included in the risk management policy will be the role and function of the health and safety committee. The health and safety committee monitors and reviews all accidents and incidents monthly. All recommendations and decisions of the health and safety committee will be discussed with all staff at team meetings to ensure learning and proposed interventions are disseminated and understood. Action 3: There will be a "Fire Safety for Fire Warden" training	31 August 2013

course in August. This training will be delivered by the company that services our fire fighting equipment e.g. extinguishers. Exact date to be confirmed. The five bank/relief RNs that have to complete fire safety training will be required to attend this training, if the do not attend they will be removed from our bank staff and no longer be employed by the Centre to cover shifts. The fire warden training is for registered nurse and key personnel in the centre. Action 4: Emergency Lighting. The annual maintenance and servicing of our emergency lighting system is due for re-certification in August 2013. This service takes approximately three hours to complete and it is under contract to a BESS registered certified electrician and in accordance with the requirements of I.S 3217 installations. Upon completion of this annual service and maintenance an inspection will be completed. The inspector will issue a Certificate of Declaration of Conformity for Emergency Lighting. This certificate will be kept in the fire safety register log book and a copy will be mounted on the wall beside the fire alarm panel. The quarterly test of the emergency lighting system is completed in-house by our maintenance team under instruction and guidelines of the BESS registered contractor. The quarterly test takes approx 30 minutes to complete and it will be done in November, February and May. The results of this test will be recorded in the Fire Register, Section 7. The fire register log book will be audited and the results of the audit will be reviewed by the governance body. Action 5: The emergency plan has been revised to include guidelines and actions to be followed in the event of loss of heat, gas, power and water supply.	

Outcome 8: Medication management

The provider is failing to comply with a regulatory requirement in the following respect: Practice in relation to the management of medication errors required improvement.
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: Action 1: All Registered Nurses working in the centre are receiving training on the management of medication errors. This training is been completed in conjunction with our supplying pharmacist and our medication management policy. All RNs have received a copy of the policy and procedure on managing medication errors. As part of the training each RN will receive a case senario outlining a medication error. Each RN will be required to manage the case, reporting, recording, follow-up including outcome, lessons learned and actions required to avoid reoccurrence. Each RN will have a medication management competency assessment completed. Prior to the competency assessment each RN will be required to submit a completed questionnaire that we are developing that will reflect their knowledge of the medication management policies and procedures, including the management of medication errors. Action 2: We have adapted the "Standards for practice in residential care Policies, Procedures, Guidelines and Templates" published by NHI, HSE and Boots in 2009. All RNs are receiving on-going support and education on this document. We are using a revised requisition template for ordering and checking of received medication from the pharmacy. We are monitoring practices related to ordering, prescribing, storing and administration of medication to our residents.	30 September 2013

We continue to work closely with our pharmacist and IT support to ensure that the Cardex and MAR sheets in use are to standard. The printing of MAR sheets has been reverted back to our supplying pharmacy. The practice of transcribing of prescriptions will only occur if it is deemed to be in the best interest of the resident. Nominated nurses will be designated the responsibility of transcriptionists if there is a need to transcribe. A copy of the "Standards for practice in residential care" has been given to the pharmacy. We will continue to work closely with our supplying pharmacy to ensure that the procedures and guidelines outlined in our PPGT are adhered to.	

Theme: Effective care and support

Outcome 11: Health and social care needs

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

Improvements were required in relation to the management of behaviours that challenged, falls and restraint.

Improvements were required in the care planning process to ensure that care plans reflected the needs of residents and to ensure that residents were involved in the care planning process.

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:

Revise each resident's care plan, after consultation with him/her.

Reference:

Health Act, 2007
Standard 13: Healthcare
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 with timescales:	Timescale:
Provider's response: Action 1: In response to identified need for improvements in the areas of Falls, Behaviour that Challenges and Restraint Management we have set up 3 x working groups. Each group will have 3-4 care team members, i.e. A Key Nurse, a CNM and 1-2 HCAs. Each group will be responsible for the review of current PPGTs and practice. Recommendations and results of the review of PPGTs will be brought to a Policy and Procedure Review meeting scheduled for 23rd August 2013. Recommended changes to PPGTs will be discussed and proposed changes and intervention will be to a high standard of evidence-based nursing practice. A series of educational/training sessions related to Fall prevention & management and Restraint Management are due to commence 27 August 2013. Training on Nutrition and Falls is scheduled for 28 August 2013. Behaviour that Challenges: Assessment for the causes of and the ruling out of physiological causes e.g. Delirium will be completed when a resident exhibits Behaviour that Challenges. In line with evidence based nursing practices we are updating our PPGTs to include the use of Behavioural Analysis Form Confusion Assessment Method CAM & Brief Agitation Rating Scale BARS to assess possible root causes of behaviour that challenges. Behaviour and Psychological Symptoms of Dementia BPSD will be further researched by PIC and the Key Nurse with responsibility for this area. When a resident exhibits Behaviour that Challenge a Behavioural Analysis Form will be completed. Immediate interventions to resolve the situation and behaviour will be in the best interest of the resident.	6-8 weeks: September 2013 for Action 1 Action 2 & 3 is on-going.

Person-centred individualised NCP will be developed to include known Triggers, avoidance of Flashpoint, management interventions and prescribed care in conjunction with the resident, representative, care team and MDT. Monitoring and evaluation of NCP & interventions will be a minimum 3 monthly or sooner if indicated in conjunction with the resident and/or representative and the care team. Action 2 & 3: All residents have a named nurse. This nurse will work closely with the resident and/or representative and the care team in assessing the individuals needs and the development of agreed goals and care interventions for each resident. Planned 3 monthly formal reviews are to be scheduled with each resident and/or representative to discuss and evaluate the Care Plan.	

Theme: Person-centred care and support

Outcome 13: Complaints procedures

The provider is failing to comply with a regulatory requirement in the following respect: The policies and procedures in relation to the management of complaints did not meet the requirements of the Regulations.
Action required: Provide written operational policies and procedures relating to the making, handling and investigation of complaints from any person about any aspects of service, care and treatment provided in, or on behalf of a designated centre.
Action required: Ensure the complaints procedure contains an independent appeals process, the operation of which is included in the designated centre's policies and procedures.
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: Action 1 & 2: A review and update of the Centre's Complaints Management Policy and Procedure has been completed. The policy and procedures states clearly the name of the complaints officer, the appeals officer and the independent person who will review any complaint not resolved to the complainant's satisfaction at any Stage of the Complaints Process as outlined in the Policy. A revised complaint form has been developed for complainants use. A complaints management checklist has been developed and all Registered Nurses have been given a copy of this. There will be on-going training and support in the management of complaints for all staff and the topic of complaints and lessons learnt has been added to the fixed agenda for staff meeting. The revised complaints form and checklist compliments the computerized system in use in our Centre. All complaints will remain open until such time as an outcome, a satisfactory resolution and lessons learnt have been achieved. Post investigation review will guide policy and procedure development to avoid reoccurrence. A full review and audit of all complaints will be conducted quarterly by the Governance Body.	12 July 2013

Theme: Workforce

Outcome 18: Suitable staffing

The person in charge is failing to comply with a regulatory requirement in the following respect: The skill mix of staff required review in order to ensure it met the needs of residents at all times.
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.

Reference: Health Act, 2007 Regulation 16: Staffing Standard 23: Staffing Levels and Qualifications	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Action 1: A comprehensive audit of our staffing levels in relation to the assessed needs of our residents has been completed. In the Queen of Peace our staffing levels exceed RQAI recommendations resident: staff ratios in respect of their assessed needs. We do meet the minimum number of nursing hours to resident ratio in respect of resident needs. We have identified the potential benefits of restructuring the roster and nurse's shift patterns to maximize supervision and delivery of care especially late evening and early night i.e. introducing an Early and a Late RN shift, ensuring a minimum of 2 X RNs on duty daily from 07:00hrs to 22:00hrs. With the additional RN on duty this will increase the number of staff on duty from 19:30hrs to 21:00hrs to 2 X RN and 4 X HCA. Proposed changes to the roster and shift patterns are drafted and a preliminary meeting with Registered Nurses took place on 22 July 2013. Further discussion with regard to custom and practice is needed, but the revised roster is due to be introduced in early-August. Review of the new shift pattern and benefits will be monitored on-going and subject to change depending on the needs of the residents and the Centre.	31 August 2013