

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Queen of Peace Centre
Centre ID:	ORG-0000085
Centre address:	6-8 Garville Avenue, Rathgar, Dublin 6.
Telephone number:	01 497 2366
Email address:	spcqueen@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Sisters of St Paul de Chartres
Provider Nominee:	Sister Rose Nuval
Person in charge:	Helen Mullery
Lead inspector:	Deirdre Byrne
Support inspector(s):	Noelene Dowling
Type of inspection	Unannounced
Number of residents on the date of inspection:	41
Number of vacancies on the date of inspection:	4

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 judgements about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 16 April 2014 08:00 To: 16 April 2014 18:30

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

Outcome 03: Suitable Person in Charge
Outcome 06: Safeguarding and Safety
Outcome 07: Health and Safety and Risk Management
Outcome 08: Medication Management
Outcome 11: Health and Social Care Needs
Outcome 13: Complaints procedures
Outcome 18: Suitable Staffing

Summary of findings from this inspection

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

Inspectors also followed up on the previous inspections, in which a number of areas of non compliances were identified 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. The provider had also been required to take immediate action for a number of significant risks identified at that time.

At this inspection, the inspectors met Sr. Rose Nuval, the person nominated on behalf of the provider (who will be referred to as the provider for the duration of the report). The inspectors also met the person in charge Helen Mullery. A fit person interview was held with Ms. Mullery at this inspection.

The residents appeared well cared for, and by staff who were patient and respectful. The centre was in a clean condition and residents told inspectors they were very happy in the centre. The residents' complimented the staff and the quality of the food they received. There was good access to general practitioner (G.P.) services.

However, inspectors identified a number of non compliances with the Regulations at

this inspection. These included the management of fire safety in relation to staff knowledge and completion of fire drills. There were improvements identified in relation to the protection of vulnerable adults in terms of staff knowledge and the management of residents' finances. Additionally, there were improvements required in care planning and consultation of residents in their care plans. Inspectors found there were limited opportunities for residents to participate in activities, and appropriate documentation staff on file.

Inspectors followed up on areas of non compliance identified at inspections in June 2013 and January 2014, and a number remained unresolved. For example, there were 14 actions from June 2013, seven had not been completed, five were completed, and two in relation to the statement of purpose were not reviewed at this time.

The five actions completed were in relation to:

- the documentation of a risk management policy
- the management of complaints
- provision of high standard of nursing care

The seven actions not completed were:

- the emergency lighting servicing frequency
- the risk management policy not meeting the requirements of the Regulations,
- the management of medication errors
- care planning documentation.

These issues are further discussed in the body of the report and 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.

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

Theme:
 Leadership, Governance and Management

Judgement:
 Non Compliant - Minor

Outstanding requirement(s) from previous inspection:
 The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

Inspectors had on-going concerns regarding the clinical governance and leadership in the centre and the person in charge did not consistently demonstrate authority and accountability for the provision of the service.

The person in charge was a registered general nurse, had the relevant necessary experience and worked full-time in the centre. However, inspectors observed a number of issues in relation to clinical governance and supervision which included consultation with residents in care planning, care plans being updated and falls management. These issues are discussed further under outcome 11.

Inspectors also found that there was unsatisfactory complaints management by the person in charge and a failure to show record and investigate verbal complaints. It was noted that verbal complaints made by residents were not investigated by the person in charge, who was also the complaints officer for the centre.

Inspectors were also concerned that issues raised at the last inspection including the protection of residents finances, care planning and the recruitment of staff, as outlined under outcomes 6, 11 and 18, had not been adequately addressed by the person in charge. Under outcome 6 staff were not clear of the types of abuse and reporting arrangements in place. Inspectors were concerned that this issues could result in poor outcomes for residents.

The person in charge had been in post since 2013. A Fit Person interview was held with the person in charge during which she demonstrated knowledge in relation to a number of clinical areas and her responsibilities under the Regulations. Inspectors found that she had participated in continued professional development. The person in charge stated that she maintained her professional development through reading clinical documents, attending seminars and participation at in house training courses. Inspectors saw documentary evidence that she had attended mandatory training in fire safety, manual handling and the protection of vulnerable adults. She had also attended short courses in elder abuse and complaints management since the previous inspection. She has completed a courses in leadership and a diploma in management.

Inspectors were satisfied that there were satisfactory deputising arrangements in place as provided by the assistant director of nursing and the clinical nurse manager (CNM). Both of these individuals participated fully in the inspection process and both demonstrated good clinical knowledge and a satisfactory understanding of their roles and responsibilities under the Regulations although some knowledge deficit was noted in the area of investigating an allegations of abuse.

The person in charge was supported in her role by the provider. Since the previous inspection, the person in charge with her formally every two weeks discuss management issues. There was a new board of management which was put in place following the last inspection. Inspectors read the minutes of the first meeting that was held in April 2014. The new board had proposed that is would be called an "advisory committee". The provider was requested to inform the Authority of any proposed changes to the new board of management.

Outcome 06: Safeguarding and Safety

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

Theme:

Safe Care and Support

Judgement:

Non Compliant - Major

Outstanding requirement(s) from previous inspection:

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

Findings:

Inspectors found the measures in place to protect residents from being harmed or experiencing abuse were not robust and improvements were required.

At the previous inspection in January 2014, inspectors were concerned that the policy on the protection of vulnerable adults had not been followed in relation to an investigation of alleged abuse. At this inspection, the inspectors reviewed a recently revised comprehensive policy on the protection of vulnerable adults. However, inspectors were still not satisfied that it was implemented in practice. For example, some staff were not familiar with the types of abuse and some staff were not clear of the reporting system in place. This posed a risk to residents if an incident was to occur again. Inspectors read records that confirmed staff received training on identifying and responding to elder abuse. An external company was contracted to carry out training for staff since the previous inspection. However, some staff reported they had yet to complete training. This was discussed with the person in charge who outlined the additional training to be carried out. She said it is a theme that is frequently discussed at staff meetings.

A number of notifications of alleged or suspected abuse had been notified in the Chief Inspector prior to the last inspection in January 2014. At that inspection, inspectors were concerned with the overall response and management of an allegation of abuse. Immediate actions were issued to the provider following the inspection to provide assurances to the Authority. The systems in place to investigate allegations of abuse were reviewed again at this inspection. Inspectors discussed the two ongoing notified allegations of abuse which had been reported to the Chief Inspector. A report for one investigations been to be submitted to the Authority. However, no report had had been submitted for the other investigation. Additionally, there was no evidence of feedback to the residents or the families who the allegation was related to. This was discussed with the person in charge who confirmed an update would be submitted to the Chief Inspector following the inspection. Following the inspection an update on the allegation was submitted. The inspectors found the person in charge was now knowledgeable of the procedures to be followed into the investigation of an allegation of suspected abuse. Along with the provider, the person in charge had attended training in the management of allegations of abuse in February 2014.

Inspectors reviewed the system in place for the safekeeping of residents' money. A new method of managing monies had been introduced since the previous inspection which was outlined to inspectors. However, improvements were identified to ensure withdrawals from residents personal accounts were carried out in a transparent and accountable manner. For example, inspectors read records of withdrawals carried out by the staff and an external service provider from residents accounts. There was no evidence if consent or authorisation had been given by the resident to allow persons other than staff withdraw monies on their behalf. Additionally, there was no policy on the management of residents personal finances, therefore no guidance was available to direct staff. Inspectors were informed a policy had been recently drafted but it had yet to be implemented or seen by staff. This had been an action at the previous inspection was not completed.

Residents spoken with confirmed to the inspectors that they felt safe in the centre, and would talk to the nurses if they had concerns.

Outcome 07: Health and Safety and Risk Management

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

Theme:

Safe Care and Support

Judgement:

Non Compliant - Major

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

Inspectors found there were systems in place to promote and protect the health and safety of residents. However, areas of improvement were identified in relation to the management of fire safety and the risk management policy.

Inspectors found the systems in place to protect residents in the event of fire were not adequate. Records seen by inspectors confirmed all staff had up-to-date fire safety training. However, some staff spoken to were not aware of what to do in the event of a fire in the centre. For example, staff could not clearly describe what to do in the event of a fire, or if the drill went off unexpectedly. Inspectors were informed that training did not involve a simulated evacuations or practice of the procedure to follow in the event of a fire. Additionally, there was no evidence of fire drills having taken place in the centre, and staff could not tell inspectors if they had taken part in a drill.

There were records to show that the fire alarm system was serviced regularly and fire equipment was serviced annually. Inspectors saw the fire emergency system was every quarter. However, as reported at the previous inspections there was no evidence to demonstrate what was a suitable frequency between checks of this system.

Inspectors also saw fire exits were routinely checked and were unobstructed. Fire procedures were prominently displayed throughout the centre. Each resident had a personal emergency evacuation plan that was frequently updated.

There was a safety statement in place that was seen by inspectors. A risk management policy was reviewed however; it did not fully meet the requirements of the Regulations. For example, it did not include the precautions in place to manage specified risk such as self harm and missing person. This had been an issue at previous inspections was not completed.

Although the person in charge informed inspectors of an annual health and safety audit carried out in the centre, there was no risk register developed which outlined the environmental risks in the centre and the procedures in place to prevent them from occurring. As a result not all areas of risk in the centre had been appropriately identified and managed. For example, windows in the sitting room on the first floor could be opened as wide as possible, and this posed a risk to residents. Inspectors saw that restrictive opening devices had been provided on windows in other parts of the building. The provider informed inspectors that a company had been contracted to provide equipment to address this and a written quotation was seen by inspectors.

Inspectors met the two maintenance officers who gave an overview of the routine safety checks that were carried out in the centre. A sample of checklists were read and they included monitoring of the temperature radiator surfaces and call bells.

There were arrangements in place for the management of adverse event involving residents. Near misses, falls and incidents were documented on detailed report sheet, and the action to be taken was recorded. However, there was inconsistent evidence that some residents care plans were updated after incidents to ensure the most effective measure were in place to prevent recurrence such as a fall or a choking incident. This is discussed further under outcome 11.

Inspectors found safe flooring was provided throughout the centre. There were hand rails in all communal areas and grab rails were located in toilets and bathrooms. Inspectors saw residents manual handling assessments were updated at routine intervals and a copy was kept on each residents file to provide direction to staff. Training records confirmed most staff had completed up-to-date training in the safe moving and handling of residents. However, some staff had yet to complete the training. Inspectors were informed a staff member had recently completed a train the trainer course and would facilitate training from May 2014. Staff were observed to follow, and spoke of procedures that were in line with best practices in the moving and handling.

There was a detailed emergency plan in place that also addressed issues such as loss of power or water supply, this had been an action at the previous inspection and was now completed.

Outcome 08: Medication Management

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

Theme:

Safe Care and Support

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

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

Findings:

Inspectors found residents' were protected by the medication management policies and procedures for the centre. However, improvements were identified in relation to the medication management policy and medication errors.

There was a medication policy in place that was reviewed by inspectors. However, it was not fully comprehensive to guide practice. For example, it did not include procedures for the management of "as required" (PRN) medications.

Inspectors reviewed a sample of residents' prescription and administration sheets. Overall, good practices were found and medications administered were individually signed by the administering staff. A small number of medication errors had occurred in the centre. Incident records were maintained and an investigation was carried out and overseen by the person in charge. However, improvements were identified in the the review and learning from errors. For example, a sample of error reports read by inspectors did not outline the actions to be carried out to prevent similar errors from recurring and the learning for staff. This was an action from the previous inspection and was not completed.

Inspectors found that regular reviews of medication practices were undertaken, and there was evidence of three-monthly medication reviews by a G.P. which were recorded in residents' medical notes. The pharmacy also completed regular audits, and inspectors read reviews and actions taken.

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

All nursing staff had undertaken medication management training. Inspectors spoke to staff and found them to be knowledgeable of the medication administration procedure.

Outcome 11: Health and Social Care Needs

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

Theme:

Effective Care and Support

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

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

Findings:

Inspectors found systems were in place to meet the health care needs of residents. However, improvements were identified in relation to the management of falls, aspects of the care planning process and activities for residents.

Inspectors reviewed a sample of resident care plans which were in electronic format. Residents were regularly assessed for a range of clinical needs, and care plans were developed for residents identified needs. There was evidence of regular review of care plans. However, improvements were identified to ensure care plans were updated following a change in residents needs or after an incident or accident. For example, following a fall or a choking incident. Additionally, there was no evidence of consultation with residents on their care plan. This had been an action at the previous inspections and was not completed.

The practices around the management of falls required improvement. Inspectors saw a falls prevention policy was in place. However, it was not fully implemented in practice. For example, the post falls procedures were not consistently followed by staff after a resident fell. While documented neurological observations were completed there were gaps in the information recorded, and there was no falls diary for residents. This had been an action at the previous inspections and was not completed. When a fall occurred a post falls assessment was completed. Inspectors read accident/incident forms. Generally, the mobility care plan was updated, with some improvements identified as outlined in the paragraph above.

There were good practices in the management of residents hydration and nutritional needs however, an area of improvement was identified. There was a detailed policy in place which provided direction to staff. Inspectors identified eleven residents who were on a modified consistency diet. However, there was no evidence these were as based on

an up-to-date appropriate assessment by a health professional, or subject to regular review. There was no evidence of residents being referred to a speech and language therapist (SLT) where necessary. Inspectors saw residents were regular monitored and those at risk had additional monitoring was carried out. Care plans were developed to guide residents nutritional and hydration needs. Inspectors saw where supplements were recommended for residents these were prescribed.

Inspectors found the social care needs of residents in the centre required improvement. There was a programme of activities displayed at the sitting room which outlined the activities provided for residents. It was noted these took place once a day for one to two hours a day, and consisted of mostly group activities such as an exercise class, or bingo, and on other days, music sessions or mass was facilitated. However, the inspector found there were a number of residents who were unable or unwilling to leave their rooms during the day. The range of activities provided did not extend to fully meet their identified needs.

Inspectors also reviewed the arrangements for the management of restraint, wounds, and behaviours that challenge, and found evidence of good practices in these areas. There were policies in place to guide care in these areas. There was evidence that residents were regularly assessed, and where need was identified, care plans were developed. Staff were knowledge of residents care needs, and had received training to enhance their practices. There was evidence of referral to relevant health professionals. The inspector saw daily nursing notes which provided information on the treatment and condition of the residents.

Inspectors found that residents had access to one of two G.P.s for the centre or could retain the services of their own G.P. There was an on call service available for out of hours and weekend calls. The residents had access to a range of allied health professionals, letters of referrals and appointments were seen on their files. The staff had a good understanding of the care needs of the residents.

Outcome 13: Complaints procedures

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

Theme:

Person-centred care and support

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The provider had put arrangements in place for the management of complaints. However, an area of improvement was identified.

A complaints log was maintained, and two complaints were recorded since the previous inspection. The details of each complaint were outlined, along with the outcome of the investigation and satisfaction of the complainant. The low number of complaints was discussed with the person in charge and the staff. They explained verbal complaints received in the centre were not recorded, but instead were managed as they arose. However, there was no record of verbal complaints was maintained in accordance with the requirements of the Regulations.

There was a policy on complaints seen by inspectors, and procedures were displayed at the entrance to the centre. The actions from the previous inspections were completed. For example, the appeals procedure was clearly outlined and a separate person was nominated to oversee if complaints were appropriately responded to.

Outcome 18: Suitable Staffing

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

Theme:

Workforce

Judgement:

Non Compliant - Major

Outstanding requirement(s) from previous inspection:

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

Findings:

Inspectors found there was an appropriate staff skill mix on the day of inspection. However, improvements were required in the recruitment of staff, provision of An Garda Síochána vetting for volunteers and staff knowledge of procedures.

There was a written operational staff recruitment policy in place. However, it was not fully implemented in practice. Inspectors reviewed four staff files and improvements were identified to meet the requirements of the Regulations. For example, some files did not include a reference from a previous employer, others did not have a minimum of three references or a declaration of fitness by a medical professional. This had been an action at the previous inspection and was not fully addressed. Information was subsequently submitted after the inspection by the person in charge in relation to some of the deficits in the documentation outlined. An Bord Altranais agus Cnáimhseachais na hÉireann registration numbers for all nursing staff were in place and up-to-date. The person in charge said there were no agency staff currently working in the centre. The centre would request agency staff in the event of an emergency.

Records confirmed most staff had up-to-date mandatory training. However, improvements were identified as not all staff had completed training in the movement and handling of residents or protection of vulnerable adults. These are discussed further under outcomes 6 and 7. There was evidence that staff had been provided with additional training since the last inspection in elder abuse and fire safety. As discussed under outcomes 6 and 7, inspectors spoke to a number of staff in relation to their role in the centre and the procedures in place. However, some staff were not familiar with the centres policies and procedures. For example, they were unable to describe how they would evacuate the centre in the event of a fire, or the types of abuse.

A number of volunteers and external service providers provided an invaluable service to the residents of the centre. Inspectors reviewed a sample of the documents on file. There was a written agreement regarding their role and the supervision arrangements in place. While there was no documentation of An Garda Siochana vetting for these persons available on the day inspection however, this information was later forwarded to the Authority by the person in charge.

Inspectors saw that staff rotas were maintained and a nurse was present in the centre 24 hours a day. At the time of inspection there was sufficient staff to meet the assessed needs of residents. Contingency measures were in place to cover staff on annual or sick leave. Since the last inspection, the number of nurses on duty at night time had increased from one to two. Inspectors reviewed rosters which confirmed there were two nurses on duty in the centre at any one time. Inspectors also spoke to staff who confirmed this. This had been an action at previous inspections and was now completed.

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Deirdre Byrne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Queen of Peace Centre
Centre ID:	ORG-0000085
Date of inspection:	16/04/2014
Date of response:	20/06/2014

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 03: Suitable Person in Charge

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The person in charge did not consistently demonstrate authority and accountability for the provision of the service.

Action Required:

Under Regulation 15 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge is a nurse with a minimum of three years experience in the area of geriatric nursing within the previous six years.

Please state the actions you have taken or are planning to take:

1. The PIC/DON shall undertake an education programme on the role of the PIC/DON in the regulations and how to apply this in practice. (16/06/2014)
2. The Registered Provider shall carry out annual appraisals on the PIC/DON to support

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

the PIC's development and role in the Centre. The annual appraisal shall be an agenda item on the advisory council meeting for consideration and review. (Ongoing)

3. A new job description shall be developed for the PIC/DON that clearly outlines the roles and responsibilities and authority so the PIC can carry out the role effectively. (Complete)

4. A new governance structure shall be implemented to support the management of the Centre and the PIC; this shall include a management team, MTD care group and an Advisory Board to the Centre. (Complete)

Proposed Timescale: 16/06/2014

Outcome 06: Safeguarding and Safety

Theme: Safe Care and Support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The policy on protection of vulnerable adults was not implemented in practices, for example, not all staff knew what constituted abuse or what to do in the event of allegation of abuse.

Action Required:

Under Regulation 6 (2) (a) you are required to: 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.

Please state the actions you have taken or are planning to take:

1. The PIC/DON and the CNM shall regularly review all staff's understanding and knowledge regarding elder abuse, in particular the signs of and responding to allegations or suspicions of abuse. (31/08/2014)
2. A comprehensive programme for the education and training of all staff to address all aspects of Elder Abuse shall be developed and implemented by the PIC/DON. (Completed)
3. New policies on abuse shall be implemented in full and staff will be required to review and understand these policies. (Completed)

Proposed Timescale: 31/08/2014

Theme: Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The safeguarding systems in place to manage residents finances required improvement.

Action Required:

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

Please state the actions you have taken or are planning to take:

1. The management of Resident Finances policy and procedure shall be audited by the PIC/DON every six months to determine compliance with this policy and procedure. (15 October 2014)
2. A process shall be put in place to ensure two staff members are the signatures on the withdrawal of staff finances. Clear evidence of consent shall also be required when making withdrawals. (Completed)
3. The policy and procedure shall be implemented in full. This shall be overseen by the PIC/DON. (Completed)

Proposed Timescale: 15/04/2014

Theme: Safe Care and Support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Where incidents of abuse had been investigated there was no evidence that residents were informed of the outcomes.

Action Required:

Under Regulation 6 (2) (b) part 1 you are required to: Maintain a record of all incidences where a resident is harmed or suffers abuse.

Please state the actions you have taken or are planning to take:

1. All learning from cases shall be used to improve the quality and safety of services in the Centre to ensure the health, safety and welfare of all residents are protected. (Ongoing)
2. The PIC/DON shall provide the Authority with an update report into the allegation of a sexual assault abuse of a resident. The PIC/DON provided the Authority of with an update report on the alleged sexual abuse of a resident on 08.02.14. This update included the outcome of the internal investigation, the findings and the recommendations following the internal investigation. (Completed)
3. The PIC/DON shall provide the Authority of the outcome of the Criminal Investigation and the Director of Public Prosecutions decision regarding the allegation of a sexual assault abuse of a resident. The PIC/DON provided the Authority of the outcome of the Criminal Investigation re: the alleged sexual abuse of a resident on 12.05.14. The PIC/DON was informed on 09.05.14 that following the submission of the book of evidence to the DPP, that there was not going to be a prosecution. Contact with the resident/family will be made when deemed legally appropriate. (Completed)
4. The PIC/DON shall provide the Authority of an update report into the concerns relating to potential of /suspected financial abuse of a resident by an external party. The PIC/DON has kept the family informed of the process. This matter has been referred to HSE Senior Case worker for the Protection of the Older Person. The SCW is

conducting the investigation and the resident, family and the Centres management are kept informed of the process and any updates. A full review of the resident's capacity has been conducted and the findings are that the resident is capable and competent to make independent decision in regard to financial and personal choices. A full record of the process and updates is available in the residents file. A record of the Senior Case Worker is in EPIC. (Completed)

Proposed Timescale: 13/05/2014

Outcome 07: Health and Safety and Risk Management

Theme: Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There were areas of risk which had not been suitably assessed or managed as outlined in the inspection report.

Action Required:

Under Regulation 31 (2) (a) and (b) you are required to: Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

Please state the actions you have taken or are planning to take:

1. A full revision of the Risk Management policy and the Risk Register will be conducted. Any additional actions/precautions required to reduce any identified risks, in regard to the prevention of Self Harm or Missing Person, will be included in the Revised Risk Register. (15 July 2014)

2. Individual Risk Assessments for identified residents with specific risks i.e. self-harm, absconsion, elopement and wandering will be developed. (Completed)

Proposed Timescale: 15/07/2014

Theme: Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The risk management policy did not contain all the information required by the Regulations, for example, there were no precautions on the prevention of self harm.

Action Required:

Under Regulation 31 (2) (c) you are required to: Ensure that the risk management policy covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm.

Please state the actions you have taken or are planning to take:

1. An education programme on risk management shall be carried out for all staff to ensure they are familiar with the updated policy. (31 July 2014)
2. The Centre's risk management policy shall be updated to ensure it's in line with best practice and all the requirements in the regulations. (Completed)
3. Compliance with the policy shall be audited by the registered provider on a regular basis. (Next Audit 31 October 2014)

Proposed Timescale: 31/10/2014

Theme: Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Not all staff were trained in the safe moving and handling of residents.

Action Required:

Under Regulation 31 (4) (f) you are required to: Provide training for staff in the moving and handling of residents.

Please state the actions you have taken or are planning to take:

1. A training schedule shall be developed and adhered to ensure there are no gaps in mandatory training for staff. (Ongoing)
2. Mandatory staff training compliance shall be reviewed by the CNM every 3 months. (To commence 02/07/2014 – 31/08/2014)
3. A programme shall be put in place to ensure all staff are trained on the safe moving and handling of residents. (Completed)

Proposed Timescale: 31/08/2014

Theme: Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Staff did not consistently demonstrate knowledge of what to do in the event of a fire.

Action Required:

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

Please state the actions you have taken or are planning to take:

1. Two fire Drills shall take place in April 2014. These drills shall continue to take place no less frequently than every 2 months until all staffs are aware of the procedures to be followed in the event of a fire in the Centre. (To be completed by 31 October 2014)

2. The registered provide shall assess all staff for their knowledge of what to do in the event of a fire. Staffs that are identified as requiring additional training will be required to attend this to ensure that they are aware of what to do in the event of a fire in the Centre. (To be completed by 29/08/2014)

3. The Registered Provider, PIC/DON and CNM shall assess staff knowledge of fire safety and procedures on a regular basis. (Ongoing)

Proposed Timescale: 31/10/2014

Theme: Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There was no record or evidence of regular fire drills in the centre.

Action Required:

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

Please state the actions you have taken or are planning to take:

1. Two fire Drills have taken place since the inspection 16.04.14. These drills shall continue to take place no less frequently than every 2 months until all residents and staffs are aware of the procedures to be followed in the event of the fire alarm been activated in the Centre. When this is identified fire drill will take place every 6 months. (29/04/2014)

2. Residents will be informed directly by the PIC/DON and this topic will be included in the Resident Forum Agenda. A flyer to inform all residents and visitors of "Actions to be taken in the event of hearing a fire Alarm" will be developed and circulated, and displayed prominently in the Centre. (30/06/2014).

3. The Registered Provider, PIC/DON and CNM shall assess staff knowledge of fire safety and procedures on a regular basis. (Ongoing)

Proposed Timescale: 30/06/2014

Outcome 08: Medication Management

Theme: Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The medication management policy was not comprehensive enough to guide practice.

The practices in relation to the management of medication errors required improvement.

Action Required:

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

Please state the actions you have taken or are planning to take:

1. New comprehensive medication policies and procedures shall be developed by the Centre that will be in line with the regulations requirements and best practice. This shall include a policy on PRNs. (30/07/2014)
2. The CNM will review all medication errors in the past 6 months. The implementation of Q-Pulse software shall support the management of all future medication errors. (31/07/2014)
3. All Registered Nurses working in the Centre shall receive training on the management of medication errors. (31/07/2014)
4. Each RN shall complete a medication management competency assessment. (Completed by 31/07/2014)
5. The PIC/DON shall review the compliance with medication policies and procedures every 3 months or more frequently if issues are identified. (Ongoing)
6. The Centre's Pharmacy shall audit medication practices on a quarterly basis. (Ongoing)

Proposed Timescale: 31/07/2014

Outcome 11: Health and Social Care Needs

Theme: Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There were improvements identified in the management of falls and nutrition as outlined in the inspection report.

Action Required:

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

Please state the actions you have taken or are planning to take:

1. The PIC/DON shall ensure the falls prevention policy is fully implemented in practice, in particular the post falls procedures. All Nursing Staff shall be further educated on the new procedure. (30/06/2014)

2. A SALT shall be scheduled to assess the all residents on modified diets to review the appropriateness of the diet. (09/06/2014)
3. The PIC/DON will ensure a SALT is available to the Centre on an ongoing basis to ensure all residents have the appropriate diet to meet their needs. (Completed – 26/05/2014)
4. The PIC/DON shall review on a monthly basis, compliance with the falls policy and the outcome of the referrals for SALT assessments will be evaluated monthly. (Ongoing)

Proposed Timescale: 30/06/2014

Theme: Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The activities available do not reflect the capacities and interests of each individual resident.

Action Required:

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

Please state the actions you have taken or are planning to take:

1. A full time Activity Co-ordinator shall be appointed to manage and support the new programme. This person shall complete the FETAC Level 5 Activities for Living Patient Care programme. (Complete)
2. A full review of the activities programme shall be carried out to identify areas for improvement. This shall include a review of resident's preferences and will be cognisant of the needs and abilities of the residents. The output will be a new activities programme that provides opportunities for each resident to participate in activities appropriate to his/her interests and capacities. (31/06/14)
3. A resident survey questionnaire and analysis of completed questionnaires. Also a number of activities will be trialled and observational assessment of activities will be executed to support the development of a comprehensive, appropriate programme that will best suit the residents in the Centre. (31/06/14)
4. A new policy and procedure on developing and managing the activities programme shall be developed. (Completed)
5. The activities programme will be reviewed and updated on a quarterly basis by the PIC/DON. (Ongoing)

Proposed Timescale: 30/06/2014

Theme: Effective Care and Support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

There was inconsistent evidence that care plans were updated to reflect residents needs after a change in circumstance.

Action Required:

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

Please state the actions you have taken or are planning to take:

1. All assessments and care plans shall be reviewed by PIC/DON or CNM to ensure they are in line with best practice and to ensure they are up to date in line with the regulations. (30/07/2014)
2. The electronic resident record system shall be set up to ensure all care plan review times are accurate and the review dates are clearly stated. All RNs will be trained on how to effectively audit a resident's Assessment and Care Plan file. All RN's will be trained how to access information from the electronic record system. (30/07/2014)
3. All Registered Nurses shall be assigned named residents. These RNs will be responsible and accountable to the PIC for the completion for all Assessment and Care Plans for their assigned residents and in particular after a change to the resident's condition. All finding from Assessment will be reflected in Care Plans. (27/06/2014)
4. All Assessments and Care Plans shall be audited on a monthly basis by the CNM to ensure there is evidence of resident/representative involvement & consultation in the assessment and care planning process. (Ongoing)

Proposed Timescale: 30/07/2014

Theme: Effective Care and Support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

There was inconsistent evidence of consultation with residents or their representative in their care plan.

Action Required:

Under Regulation 8 (2) (c) you are required to: Revise each residents care plan, after consultation with him/her.

Please state the actions you have taken or are planning to take:

1. All care plans shall be reviewed to ensure the resident/representative is consulted with in the development of the individuals Care Plan. All gaps identified shall be rectified by the resident's assigned Registered Nurse. (30/07/2014)

2. All Registered Nurses shall be assigned named residents. These assigned RN will be responsible and accountable to the PIC/DON for the inclusion of the resident/representative in the development, evaluation and updating of his/her Care Plan. Where a resident does not have the capacity to be consulted in this process their representative/advocate will be consulted in this process. (27/06/2014)

3. All Assessments and Care Plans shall be audited on a monthly basis by the CNM to ensure there is evidence of resident/representative involvement/ consultation in the care planning process. (Ongoing)

Proposed Timescale: 30/07/2014

Outcome 13: Complaints procedures

Theme: Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There was no record of verbal complaints maintained in the centre.

Action Required:

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

Please state the actions you have taken or are planning to take:

1. A new policy on the Management of Complaints shall be fully implemented in the Centre. All verbal complaints shall be documented and managed in line with the Centre's new policy. (Complete)

2. All staff shall receive education and training on the new policy. (Complete)

3. Compliance with the complaints policy will be reviewed by the registered provider on a regular basis. (Ongoing)

Proposed Timescale: 13/05/2014

Outcome 18: Suitable Staffing

Theme: Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

There were improvements identified in relation to staff knowledge of the centres policies and procedures. For example, the protection of vulnerable adults and fire prevention measures.

Action Required:

Under Regulation 17 (3) you are required to: Make staff members aware,

commensurate with their role, of the provisions of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 as amended, the statement of purpose and any policies and procedures dealing with the general welfare and protection of residents.

Please state the actions you have taken or are planning to take:

1. A Quality Improvement Programme shall be put in place that will update the Centres' process with policies and procedures to reflect requirements under Regulation 17 (3). This process shall include education and training on the new policies and procedures for all staffs in the Centre to make them aware, commensurate with their role, of the statement of purpose and all policies and procedures required to enable them to deal with the general welfare and protection of residents. This training will be conducted on a monthly basis. (Ongoing)
2. A weekly policy discussion group shall be set up focusing on specific care and service themes to further enhance staff knowledge. (Ongoing)
3. A new document control system shall be implemented that shall enable staff easy access to policies and procedures and the statement of purpose. (31/07/2014)
4. The Registered Provider, PIC/DON and CNM will audit staffs knowledge and understanding of the Centre's policies and the statement of purpose on a monthly basis. (Ongoing)
5. Multi-disciplinary Care and Service groups shall be established – where best practice, Centre's policy, practices and the statement of purpose shall be on the agenda. (Completed)

Proposed Timescale: 31/07/2014

Theme: Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The documentation on staff files did not consistently meet the requirements of Schedule 2 of the Regulations such as a minimum of three references including a previous employer and fitness to work.

Action Required:

Under Regulation 18 (2) (a) and (b) you are required to: 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 have been obtained in respect of each person.

Please state the actions you have taken or are planning to take:

1. The PIC/DON shall initiate and oversee a full audit of all current staffs' records. Any gaps such as An Garda Síochána vetting, fitness to work and references will be identified. Follow up and rectification of any identified gaps in documentation as per Schedule 2, such as An Garda Síochána vetting, fitness to work and references, will be

addressed. (31/06/14)

2. All staff files will be updated to reflect sickness leave, annual leave, ongoing education, professional development, training attended and appraisals no later than the 15th of every month to reflect all activities for the previous month. A report of leave, education, training & appraisal will be provided to the Management Team for review monthly. (29/08/2014)

3. All staff files will be audited every 6 months to ensure compliance with Health Act, Standards and Regulations (Ongoing)

Proposed Timescale: 29/08/2014