<table>
<thead>
<tr>
<th><strong>Centre name:</strong></th>
<th>Queen of Peace Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Centre ID:</strong></td>
<td>OSV-0000085</td>
</tr>
<tr>
<td><strong>Centre address:</strong></td>
<td>6-8 Garville Avenue, Rathgar, Dublin 6.</td>
</tr>
<tr>
<td><strong>Telephone number:</strong></td>
<td>01 497 5381</td>
</tr>
<tr>
<td><strong>Email address:</strong></td>
<td><a href="mailto:spcqueen@eircom.net">spcqueen@eircom.net</a></td>
</tr>
<tr>
<td><strong>Type of centre:</strong></td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td><strong>Registered provider:</strong></td>
<td>Sisters of St Paul de Chartres</td>
</tr>
<tr>
<td><strong>Provider Nominee:</strong></td>
<td>Rose Nuval</td>
</tr>
<tr>
<td><strong>Lead inspector:</strong></td>
<td>Deirdre Byrne</td>
</tr>
<tr>
<td><strong>Support inspector(s):</strong></td>
<td>Helen Lindsey</td>
</tr>
<tr>
<td><strong>Type of inspection</strong></td>
<td>Announced</td>
</tr>
<tr>
<td><strong>Number of residents on the date of inspection:</strong></td>
<td>42</td>
</tr>
<tr>
<td><strong>Number of vacancies on the date of inspection:</strong></td>
<td>3</td>
</tr>
</tbody>
</table>
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 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 the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 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 inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From: To:
11 August 2014 09:00 11 August 2014 18:00
12 August 2014 08:00 12 August 2014 17:00

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

<table>
<thead>
<tr>
<th>Outcome 01: Statement of Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 02: Governance and Management</td>
</tr>
<tr>
<td>Outcome 03: Information for residents</td>
</tr>
<tr>
<td>Outcome 04: Suitable Person in Charge</td>
</tr>
<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
</tr>
<tr>
<td>Outcome 06: Absence of the Person in charge</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
</tr>
<tr>
<td>Outcome 10: Notification of Incidents</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
</tr>
<tr>
<td>Outcome 14: End of Life Care</td>
</tr>
<tr>
<td>Outcome 15: Food and Nutrition</td>
</tr>
<tr>
<td>Outcome 16: Residents' Rights, Dignity and Consultation</td>
</tr>
<tr>
<td>Outcome 17: Residents' clothing and personal property and possessions</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
</tr>
</tbody>
</table>

Summary of findings from this inspection

This announced inspection took place to inform a decision to renew the registration of the designated centre following an application made by the provider. It took place over two days and assessed compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland 2009. It also focused on the issues arising from the previous inspection carried out in April 2014. As part of this inspection, inspectors met with residents and staff members, observed practices and reviewed documentation such as care plans, accident logs, policies and procedures.
Significant non-compliances were identified during the previous inspections in January 2014 and April 2014. Following the inspection in January 2014 the provider nominee was requested to attend a meeting with the Health Information and Quality Authority (the Authority) to discuss these significant non-compliances with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

At this inspection inspectors were concerned with the poor governance and overall management of the centre. Specifically they were concerned with the fitness of the registered provider as they found that there was an overall failure of the registered provider to adhere to the requirements of the Regulations. The nominee of the registered provider had failed to address a number of the non-compliances from the previous inspection and was unaware of how to address other significant risks in the centre such as the implementation of the policy of protection of vulnerable adults, ongoing management of risk, and the management of falls. Inspectors were also concerned that actions deemed to be completed by the registered provider had not been completed within the agreed time frames.

Unsolicited information received by the Authority prior to the inspection in relation to seating assessments was reviewed. Inspectors were satisfied that there was appropriate access to occupational health services and residents were adequately assessed where required.

This inspection focussed mainly on the 17 required actions from the previous inspection relating to 6 Outcomes and other areas where improvements were required. At this inspection it was noted that only 11 of the actions were completed including:

- the provision of activities appropriate to residents assessed needs and capabilities
- the systems in place to safeguard residents finances
- staff knowledge of fire evacuation procedures.

Other areas that were work in progress and required further improvement included:

- the completion of drills on a regular basis
- the implementation of the policy on protection of vulnerable adults

Actions not addressed included:

- the ongoing identification, assessment and management of risk,
- the provision of up-to-date movement and handling training for all staff.
- the management of falls

Other areas of non compliance identified at this inspection include, the maintenance of operational policies, the management of complaints, aspects of health care needs, review of the safety and quality of care provided, and the investigation of serious incidents involving residents, medication management.
These items are discussed in the body of the report and are included in the Action Plan at the end of this 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 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

### Outcome 01: Statement of Purpose

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Inspectors found the statement of purpose for the centre did not meet the requirements of Regulation 3 and Schedule 1 of the Regulations.

The statement of purpose did not accurately reflect the services provided in the centre. For example, the admission criteria for new residents states that persons with behaviours that are challenging and with an exit seeking behaviour are not suitable to the service and the design and layout are not conducive to this type of needs. However, a number of residents presented with behavioural issues during the inspection.

In addition, inspectors a number gaps in the information as required by Schedule 1 of the Regulations were identified. For example, the information set out in the conditions of the current Certificate of Registration, the deputising arrangements for the person in charge, the supervision arrangements in place for therapeutic services and arrangements for respecting the residents privacy.

**Judgment:**
Non Compliant - Moderate

---

### Outcome 02: Governance and Management

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

Findings:
Inspectors found there was a clearly defined management structure that outlined the lines of authority and accountability. However, improvements were required in the system in place to review the quality and safety of life of residents.

There was a system in place to monitor the quality and safety of care and the quality of life of residents. Inspectors reviewed documentation of internal audits and externally carried out reviews. Audits carried out included a monthly clinical audit, nutrition care audit and a care planning audit. However, improvements were identified, there was no evidence of the change brought about or the learning from monitoring carried out. Additionally, residents and families were not involved or consulted with for feedback.

There was an advisory council in place which consisted of the provider nominee and three external persons. Minutes read by inspectors confirmed meetings took place at regular intervals and discussed a range of issues regarding the operation of the centre. A management committee had been set up in early 2014, with membership including the provider, the person in charge and heads of each departments. The minutes confirmed a range of issues were discussed including residents health care needs and risk management.

Judgment:
Non Compliant - Moderate

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors found a guide to the centre was available to residents and a contract of care was provided to each resident on their admission to the centre. However, there were gaps in the information required to be included as required by the Regulations.

The residents guide to the centre was read by inspectors however, not all information as set out by the Regulations was included. For example, the terms and conditions relating to residents of the centre.

A sample of residents contract of care reviewed had been and developed within the mandatory time-frame. Each contract set out the services to be provided. However, the
contracts did not include full details of the costs of additional services provided.

**Judgment:**
Non Compliant - Minor

---

**Outcome 04: Suitable Person in Charge**
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
While the requirements for the role of person in charge were met, with regard to qualifications and experience, inspectors had some concerns regarding this outcome.

The person in charge was a registered general nurse and had the relevant length of experience required by the Regulations. She participated in ongoing professional development by attending training days in topics such as wound assessment, end-of-life care, and nutrition. She attended seminars in care of the older person. She had previously completed a Further Education and Training Awards Council (FETAC) Level 6 course in gerontology and was a trained movement and handling trainer.

The person in charge was present in the centre five days per week and was fully engaged in the management of the service. Satisfactory deputising arrangements were in place. The person in charge was supported in her role by the assistant director of nursing (ADON) who deputised in the absence of the person in charge. The ADON participated fully in the inspection process and demonstrated adequate clinical knowledge. Inspectors spoke to the ADON and it was clear she knew the residents very well and demonstrated a good understanding of her roles and responsibilities under the Regulations.

Since the previous inspection a new person in charge had been recruited and was in the role since June 2014. A fit person interview was held in the Authority offices on the 25 June 2014. At that interview, inspectors were concerned with the persons in charge’s knowledge of the key policies and procedures for the centre. Following that interview, the person in charge was advised of these deficits and that further action was required to address them. At this inspection, the person in charge sat another fit person interview. Inspectors found the person in charge demonstrated good knowledge of the Regulations and had a clear understanding of her responsibilities under the legislation. However, some areas of improvement were still required in her knowledge of the centres key policies. For example, the procedures described in relation to the investigation of an allegation of abuse and the investigation of an adverse incident involving a resident did not fully reflect policy. These matters were discussed with the...
person in charge, who undertook to address these areas. This is discussed further under outcomes 7 (protection) and 8 (health and safety).

Residents could identify the new person in charge, telling inspectors she had introduced herself and frequently met with them.

Judgment:
Compliant

**Outcome 05: Documentation to be kept at a designated centre**
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Inspectors found the operational policies and procedures as required by Schedule 5 were not fully in place and not all policies guided practice.

The policies and procedures as outlined under schedule 5 the Regulations were reviewed. However, there was no health and safety policy and no recruitment policy. Inspectors found some policies reviewed did not fully provide direction to staff. For example, the policy on restraint as outlined under outcome 7 did not describe current restrictive practices in the centre, the policy on falls did not guide staff, as discussed under outcome 11.

There was a system in place to ensure staff were suitably knowledgeable regarding the policies, and the person in charge outlined how she discussed a different policy each week. This was confirmed by staff who appeared to to be aware of the policies and reflected them in practice.

Overall inspectors saw evidence that records were maintained in the centre, were up-to-date, secure, but easily retrievable. However, training records were not maintained in a complete manner for ease of review. This is discussed further outcome 18.

There was evidence to confirm the centre was adequately insured against injury to residents, along with insurance against loss or damage to residents property.
### Judgment:
Non Compliant - Minor

### Outcome 06: Absence of the Person in charge

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

#### Theme:
Governance, Leadership and Management

#### Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

#### Findings:

The provider was aware of the requirement to notify the Chief Inspector of any proposed absence of the person in charge for a period of more than 28 days. There were appropriate contingency plans in place to manage any such absence. An assistant director of nursing (ADON) deputised for the person in charge in her absence.

#### Judgment:
Compliant

### Outcome 07: 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. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.*

#### Theme:
Safe care and support

#### Outstanding requirement(s) from previous inspection(s):

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

#### Findings:

Inspectors found systems were in place to protect residents from being harmed or suffering abuse. However, improvements were required in the implementation of the policy on protection of vulnerable residents.

There was a detailed policy on the protection of vulnerable adults that provided sufficient detail to staff on the steps to follow in the event of an allegation of abuse. However, inspectors found the person in charge and senior nursing staff, gave differing accounts to what was outlined in the policy regarding how they would investigate an
allegation of abuse. For example, the people who would sit on the investigation team. This was brought to the attention of the person in charge and the provider. The knowledge of staff of the policy had been an issue at the previous inspection and was not adequately addressed.

Records read confirmed all staff had received training in the protection of vulnerable adults, with regular training taking place. Staff spoken to were knowledgeable of the types of abuse and the reporting arrangements in place, although as outlined above improvement was required.

An allegation of abuse had been notified to the Authority prior to the inspection. Inspectors discussed the incident with the person in charge and read reports into the incident that outlined the action taken upon the allegation being made. There was evidence of feedback to the resident also during this time. This had been an action at the previous inspection and was addressed. The person in charge had commenced an investigation into the incident and advised inspectors a report of the investigation would be submitted to the Authority on its conclusion.

Inspectors found suitable arrangements were in place to safeguard residents' finances. There was a procedure in place to guide staff that was implemented in practice. An action from the previous inspection was addressed and inspectors saw records of residents cash transactions were now signed off by two staff. In addition, the system in place to withdraw residents' money was more robust with only designated staff permitted to make transactions on behalf of residents where authorised to do so.

All residents spoken to said that they felt safe and secure in the centre. Residents stated that they attributed this to the staff who said they were caring and trustworthy.

Inspectors read a policy on the management of behaviours that challenged that guided practice. However, it was not fully implemented in practice. For example, evidence based assessment tools such as Cohen-Mansfield assessment tool were not completed for the small number of residents who had behaviours that challenge. Additionally, care plans did not fully guide care. For example, the triggers and strategies to de-escalate behaviours that challenge were not outlined. Inspectors spoke to staff who could describe residents behaviours that challenged and the interventions they would follow. However, some staff said they not sure how to handle certain situations with residents. The person in charge confirmed training in this area would be provided for some staff on the 13 August 2014.

The policy on restrictive practices was reviewed by inspectors. However, as outlined in outcome 5, it did not fully guide practice. For example, it did not outline the current arrangements in place such as the use of bedrails, lap-belts and wandering tags. There were a low number of residents with physical restraint in place. There were seven residents using bedrails and three using lap belts. While bedrails were routinely risk assessed, lap-belts were not risk assessed and care plans were not put in place to guide their use. This was not fully in line with the national policy on restraint.

**Judgment:**
Non Compliant - Moderate
**Outcome 08: Health and Safety and Risk Management**
The health and safety of residents, visitors and staff is promoted and protected.

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
Inspectors found there were systems in place to protect and promote the health and safety of residents, visitors and staff. However, improvements were required as the ongoing management of risk was not robust enough and the policies in place did not to guide practice.

Inspectors reviewed the centres risk management policy which incorporated a safety statement. However, as outlined under outcome 5, inspectors found there was health and safety policy and the risk management policy did not fully meet the requirements of the Regulations. For example, it did not include the measures and actions in place to control risks such as abuse, elopement or self harm. This had been an action at the previous inspection and was not completed.

A new risk register had recently been developed since the last inspection. It was reviewed by inspectors and contained clinical and non-clinical risk assessments. However, the controls measures to manage the risk that had not been identified. Furthermore, a number of risks were identified by inspectors during the inspection had not been identified and assessed. For example:

- unlocked sluice rooms accessible to vulnerable residents
- internal smoking room and an outdoors smoking area had not been risk assessed.
- broken panes of glass were stored and a fallen brick wall in the garden

The risks identified were brought to the attention of the person in charge, who later advised inspectors locks were to be provided on the sluice room doors. Although there were routine checks carried out of hot water and radiator surfaces, there was no formal system of ongoing monitoring and assessment of risk carried out in the centre. These matters had been an issue at the previous inspection.

Inspectors found that although smoking risk assessments were completed for residents that smoked to assess their safety, they were not comprehensive enough to identify the potential risks associated with each individual resident and the control measures required to reduce the risk.

Inspectors reviewed incidents records and there was evidence of risk assessments completed for each. There was evidence that appropriate action was taken to address each incident and they were investigated in a timely manner. However, there was no
evidence of the learning or improvement to prevent these incidents from happening again. For example, residents care plans were not updated following incidents, falls or medication errors, to outline the preventative measures in place to minimise the risk of recurrence.

Inspectors saw residents were encouraged to be actively mobile and were seen being escorted around the centre. Staff were observed following best practice in the movement of residents. Inspectors read records of training provided to staff in the movement and handling of residents, however, the records showed nine staff had not yet completed training. This was also an issue at the previous inspection and not fully addressed.

There were documented procedures in place for the management of adverse events involving residents. However, they did not contain sufficient detail to guide practice. For example, the procedures to carry out an investigation following a serious incident involving a resident. The person in charge outlined how she would investigate a serious incident, however, she was could not clearly describe the procedure. This matter was also discussed with the nominee of the provider who gave a differing account of how she carry out an investigation.

Inspectors were satisfied that fire precautions were in place. Areas of non compliance from the previous inspection had been address. Fire procedures were prominently displayed throughout the centre. Service records showed that the emergency lighting and fire alarm system was serviced regularly and fire equipment was serviced annually. Inspectors noted that the fire panels were in order and fire exits, which had daily checks, were unobstructed. Inspectors read training records which confirmed that all staff had attended training within the last year. Regular fire drills were conducted including evacuation procedures, however, although staff attendance at fire drills were recorded, there were inadequate records maintained of the outcome and learning from the drills. Staff spoken with were knowledgeable of the procedure to follow in the event of a fire.

An emergency plan was in place which identified what to do in the event of fire, flood, loss of power or heat and any other possible emergency.

Inspectors found that there were measures and policies in place to control and prevent infection. Staff had received training in infection control and were knowledgeable. Staff had access to supplies of gloves and disposable aprons and they were observed using the alcohol hand gels which were available throughout the centre.

Inspectors found that there was safe floor covering and handrails throughout the centre and a passenger lift accessed each floor.

Judgment:
Non Compliant - Major
**Outcome 09: Medication Management**

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

**Theme:**
Safe care and support

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

**Findings:**
Inspectors found residents were protected by the designated centres’ policies and procedures for medication management. However, an area of improvement was identified.

A comprehensive policy was in place which guided practice, this had been an issue at the previous inspection and was addressed. Inspectors read completed prescription and administration records, and overall they observed good practices in the administration of medications. However, they observed one resident’s medications had been left by their bed and had not yet been taken, which is not in line with policy or best practice guidelines. This was discussed with the person in charge.

Staff nurses involved in the administration of medications had undertaken training updates in best practice. However, it was not clear if all staff had up-to-date training. This is discussed further under outcome 18. The person in charge informed inspectors that medication audits were completed by the pharmacy. Although records of audits were not provided during the inspection, copies were submitted by the person in charge after the inspection.

Medication errors were reviewed. There had been two errors since the previous inspection. The person in charge had completed an investigation and there was evidence that appropriate action had been taken with the learning for staff. This had been as issue at previous inspection and was addressed.

At the time of the inspections no residents were self medicating. There was no system of transcribing medications in the centre.

Written evidence was available that medications were regularly reviewed by residents general practitioner (G.P.) were carried out.

Medications that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with professional guidelines. Nurses kept a register of MDAs. The stock balance was checked and signed by two nurses at the change of each shift. Inspectors checked the balance of a sample of medication and found it to be correct.

**Judgment:**
Non Compliant - Moderate
### Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

#### Theme:
Safe care and support

#### Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

#### Findings:
Inspectors were satisfied that a record of all incidents was maintained and where required were notified within the specified time frame to the Chief Inspector.

The person in charge was aware of the requirement to notify the Chief Inspector of certain incidents. In addition, a quarterly report outlining other incidents in the centre was made to the Chief Inspector.

#### Judgment:
Compliant

### Outcome 11: Health and Social Care Needs
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. 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.

#### Theme:
Effective care and support

#### Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

#### Findings:
Inspectors found residents had good access to GP services, and to a range of allied health professionals. Nurses had a good understanding of the care needs of the residents. However, aspects of the residents’ health care management were not met specifically in relation to the management of falls. In addition, improvements were required in the review of care plans to reflect the current status and care needs of the resident.

The residents' care plans were in electronic format and a sample were reviewed with nursing staff. Overall, there were good practices found and residents were regularly
assessed using evidence based tools for a range of health care needs. Care plans were developed to guide care and there was evidence residents were consulted regarding their care. This had been an action at the previous inspection and was completed. However, inspectors found inconsistencies in detail of the action to be taken in care plans. For example, catheter care, behaviours that challenged, restraint, and end-of-life care.

Inspectors found that the overall management and prevention of falls required improvement. A notification of a residents fall resulting in a serious injury was submitted to the Authority prior to the inspection. Inspectors were concerned regarding the management of falls in relation to this incident. The provider was requested to carry out an investigation into the incident. However, a complete response was not submitted within the required time-frame by the provider, who was requested again to submit the report. At the time of writing the investigation had not yet been submitted. There was a policy in place which had been reviewed since the last inspection. However, it was not comprehensive enough to guide practice. For example, post falls procedures were not clearly outlined in the policy. This had been an issue at the previous inspection and was not adequately completed. Inspectors also read care plans for residents who had experienced injuries from falls. However, they were inconsistently updated following each fall, and did not clearly outline the interventions and strategies to prevent future falls occurring. There was evidence of regular assessments and post falls assessments carried out. Inspectors saw that controls measures were in place to protect residents such as hip protectors, alarm and crash mats. Neurological observations were completed following an unwitnessed fall or suspected head injury.

Inspectors reviewed the arrangements in place for wound care and found evidence of good practices in this area, with an area of improvement identified. There were policies in place to guide staff. There was one residents with a wound at the time of inspection. A care plan was developed that outlined the frequency and dressing type. A wound assessment chart was completed to track healing and photos were also taken. Residents were regularly assessed for the risk of developing pressures sores, with care plans where risk was identified. However, the system of review of residents with pressure relieving mattresses required improvement. Inspectors reviewed the mattress settings for residents at high risk of developing pressure sores, while most were correct, one mattress was at an incorrect setting. This could have a negative outcome for the resident.

Inspectors found residents had a choice of retaining their own G.P. and there was evidence of regular review of residents medical needs. An on call arrangement was in place for out of hours and at weekends. There was access to a range of allied health professional professional. Inspectors saw records of referrals and appointments with services including dietician, speech and language therapy, chiropody, physiotherapy and dentistry. Where recommendations were made, these were recorded and residents care plans were updated.

**Judgment:**
Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The design and layout of the centre was in line with the Statement of Purpose and met residents individual and collective needs, with an area of improvement identified.

Ongoing decoration works were taking place at the time of the inspection, and walls were in the process of being painted. Residents and relatives commented how bright and pleasant the centre looked since the work had commenced. The provider outlined proposed plans to upgrade other parts of the building in the future.

The centre was kept clean, and was well maintained to a good standard of repair. There was a large secure garden directly accessible to residents. Residents were observed enjoying sitting out during the inspection. However, as outlined in outcome 8, inspectors found broken panes of glass were stored openly and part of a wall had fallen in. This was discussed with the person in charge who undertook to address these issues.

The centre was laid out over three floors, each accessed by a lift. The ground floor housed a kitchen, dining room, offices and visitors room. The residents bedrooms were located on the first and second floors. All bedrooms were single occupancy and a number were visited by inspectors with residents permission. They were pleasantly decorated and laid out, with many residents adding their own personal touches such as photos, paintings and furniture. All bedrooms had a wardrobe and locker for personal items. Each bedroom had its own wash hand basin and 13 were provided with an ensuite shower, wash-hand basin and toilet. However, two showers had a step into them, which would not be fully accessible to all residents. There was sufficient number of toilets, bathrooms and showers to meet the needs of residents.

Adequate private and communal accommodation provided, with a chapel and large sitting area for residents to sit in during the day.

All beds had an emergency call facility and each resident was assessed for their use, and inspectors found these were regularly serviced.

There was provision of assistive equipment such as hoists and lifts. Servicing reports were read by inspectors and confirmed they had been recently serviced and were in good working order. Suitable storage was provided for assistive equipment.
Grab rails and hand rails were fitted throughout the centre.

**Judgment:**
Non Compliant - Minor

---

**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

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

**Findings:**
Inspectors found complaints were well managed, although further improvement was required.

There was a detailed complaint’s management policy in place and inspectors noted that it met the requirements of the Regulations. The complaints procedure was displayed throughout the centre and clearly outlined the appeals process and contact details. Relatives and residents who spoke to inspectors knew the procedure if they wished to make a complaint. Some residents told inspectors they would have no problem making a complaint if they needed to.

A complaints log was maintained and since the last inspection verbal complaints were now documented. However, further improvement in the documentation of complaints was required as there was no record of the investigation carried out, what action had been, and, where the residents was satisfied.

**Judgment:**
Non Compliant - Moderate

---

**Outcome 14: End of Life Care**
*Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.*

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.
**Findings:**
Inspectors were satisfied that policies and procedures were in place to ensure each resident’s end-of-life care needs were met. A detailed policy was reviewed by inspectors which provided guidance to staff.

There were no residents receiving end-of-life care on the day of inspection. There were arrangements in place to elicit resident’s end-of-life preferences. Spirituality care plans for residents. While most residents had an end-of-life care plan in place, some care plans did outline residents spiritual and emotional practices (this is discussed further under outcome 11), and one recently deceased residents had no detailed care plan. This was discussed with the clinical nurse manager who showed inspectors records of a meeting with the residents family held before their passing that clearly outlined the residents end-of-life wishes.

There was access to the local palliative care team who provided support and advice when required. The person in charge and clinical nurse manager had attended training on discussing end-of-life care with people with dementia.

A visitor’s room was available for relatives and friends for privacy if required. All bedrooms were single rooms occupancy which ensured residents received privacy and dignity at their end of life if required.

**Judgment:**
Compliant

---

**Outcome 15: Food and Nutrition**
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Inspectors were satisfied that resident's were provided with meals that were wholesome and in accordance with their assessed needs.

There was a comprehensive policy which provided guidance on the practice regarding residents nutritional and dietary needs. There were systems in place to ensure residents did not experience poor nutrition with regular assessments of residents using a malnutrition universal score test (MUST) assessment tool. There were care plans to guide practice, along with monthly weights of each resident. Where residents were at risk the person in charge carried out increased monitoring, with weekly weights, food balance sheets and referral to the dietician. Inspectors read that recommendations were
followed up by staff for example, supplements were prescribed by the G.P. were required.

Inspectors spent time with residents in the dining room at lunch time and found residents were discreetly and respectfully assisted with their meals where required. A pictorial menu was displayed at the entrance to the dining room and on each table that outlined the choice of meal for the day. A number of residents who spoke to inspectors expressed their satisfaction with the quality of meals served and choice they had. Tables were pleasantly set and residents were served as they sat. Inspectors observed meals were well presented with gravy provided in a side dish or by staff who asked residents if that was what they wanted. Music played softly in the background.

There was evidence of choice for residents on a modified consistency diet. The staff were familiar with the special dietary requirements and preferences of residents’ and were knowledgeable of the residents’ assessed needs. Since the last inspection all residents on a modified consistency diet had been assessed by a speech and language therapist. This had been an issue at the previous inspection and was addressed. The menu was reviewed by the person in charge along with the dietician to ensure quality meals and choice at meal times. Inspectors reviewed records of a nutrition survey that had been carried out. Inspectors met the chef who was familiar with the residents dietary requirements. There was an individual diet folder for kitchen staff that included information on residents diet, fluids, and what assistance was required.

Inspectors saw residents being offered a variety of snacks and fresh water, fruit juices and hot drinks during the day.

Judgment:
Compliant

**Outcome 16: Residents’ Rights, Dignity and Consultation**
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. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Inspectors found residents were consulted with and participated in the organisation of the centre. Their privacy and dignity was respected and had opportunities to participate in activities appropriate to their interests and preferences.
There were systems in place to ensure residents were consulted about how the centre was planned and run and to facilitate participation in the organisation of the centre. A residents’ committee met regularly and an independent residents advocate facilitated the meetings. The minutes of the last meeting held in May 2014 were read. Comments raised included noise at nighttime and staff levels. The person in charge outlined the action taken to address each comment raised. Residents told inspectors they attended the meetings and found them beneficial.

Voting rights were respected, and a polling booth was set up by the local county council at each election or referendum. The CNM provided details of newly admitted residents to the council. Residents informed inspectors they had exercised their vote at the last election.

Religious and spiritual needs of residents were respected. The centre had was ran by a religious order with a Roman Catholic ethos and many residents chose to live in the centre because of this. Residents told inspectors they enjoyed attending mass that was held each day in the chapel on the second floor. The person in charge outlined the services available to the residents. Residents of other religious denominations were facilitated also.

There were no restrictions on visits except where requested by residents. There were arrangements in place for residents to receive visitors in private and a visitors room was available. The residents had access to a private telephone booth located on each floor. There were televisions provided and available in each bedroom. The newspapers were available each day including weekends.

Overall, residents received care in a dignified way that respected their privacy at all times. Inspectors observed staff chatting and sitting with residents. It was noted that a small number of staff had some difficulty understanding inspectors questions. This was discussed with the person in charge who assured inspectors staff were very aware of the requirement to communicate at all times in a clear manner and in the English language. The residents seemed comfortable and happy in their surroundings. Inspectors spoke to a number of residents, families and staff and all expressed their satisfaction with the centre.

Residents communication needs were highlighted in care plans and reflected in practice. For example, a resident with a visual impairment had a detailed care plan, that outlined additional communication needs.

There were adequate facilities for recreation with a number of sitting areas for residents to choose to sit in, including a large living area, library. A hairdressers room was located in the centre, and a number of residents were getting their hair done during the inspection.

Inspectors were satisfied residents had opportunities to participate in activities that were meaningful and purposeful and in accordance with their interests. An action from the previous inspection regarding provision of appropriate activities for residents was now adequately addressed. A full time activities coordinator facilitated activities along a second person who was on leave during the inspection. Inspectors spoke to the
coordinator who outlined the programme of activities, including dancing, chatting and reading with residents. Some residents preferred to go to the chapel for mass while others enjoyed observing activities taking place. An external service provider facilitated sonas (a music and sensory therapy for residents with a communication impairment) that took place twice a week in the centre. Each resident had a "key to me" developed, a document that outlined their background, family, interests, hobbies and likes. An activities assessment was completed also that ensured activities were appropriate to their needs, likes and preferences.

**Judgment:**
Compliant

---

### Outcome 17: Residents' clothing and personal property and possessions

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

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Inspectors found residents had adequate space for their personal belongings and their clothes were suitably laundered and returned to them.

There was a policy on residents personal property and possessions. The person in charge was in the process of completing an up-to-date list of personal possessions for residents, and although work had commenced on this, nearly half of the residents’ had no list in place. This was discussed with the person in charge who said all residents would have a list in place by the middle of September.

Residents were encouraged to personalise their bedrooms. Many of the bedrooms were decorated with pictures and photographs from residents’ own homes. There was adequate storage space for residents clothing and belongings.

Clothing items were clearly marked with the name of the resident. An external laundry service was used and was available seven days a week. Inspectors talked to residents who confirmed they were satisfied with the way in which their clothes were cared for and were happy with the service.

**Judgment:**
Non Compliant - Minor
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. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
Inspectors found that the current staffing levels, qualifications and skill mix were appropriate for the assessed needs of residents on the day of inspection. However, improvements were identified in the skill mix of staff at weekends and certain times of the day. Further improvements were required in relation to vetting of external service providers.

Inspectors found there were adequate staffing levels and skill mix on the days of inspection. There were two nurses on duty at all times. A two week roster was read that accurately outlined the staff on duty. It was noted that the number of nurses on duty reduced from 4 to 2 after 3.30pm till 7.30am the next day. There were two nurses on duty at weekends. Although inspectors did not observe any negative outcomes for residents, and found the staffing levels met the layout of the centre, some residents and relatives commented that the number of nurses at times was not adequate.

Inspectors did not review the recruitment policy as it was not available, it was requested from the provider, but not produced. The inspectors reviewed a sample of staff files and found recruitment practices were in line with the Regulations. This had been an action at the previous inspection and was addressed.

Inspectors reviewed a sample of files and found that nursing staff had up-to-date registration with An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) for 2014. The person in charge informed inspectors that there were a number of volunteers and external service providers working in the centre. These files were reviewed. However, there were some gaps in the information required by Regulations. For example, an Garda Síochána vetting was not in place for two persons. The person in charge undertook to address this matter.

There was education and training available to staff in a broad range of areas. Inspectors saw records of attendance sheets for training completed by staff which included emergency planning, care planning, risk management, nutrition, complaints and continence promotion. However, it was difficult for inspectors to identify the training completed by individual staff and whether all staff had up-to-date training in areas such
as elder abuse, manual handling and medication management. Furthermore, staff required training in areas to address the specific clinical needs of residents such as falls and behaviours that challenged. The person in charge informed inspectors training in behaviours that challenge for residents with dementia would take place on the 13 August 2014.

**Judgment:**
Non Compliant - Moderate

---

**Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings.

**Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

**Report Compiled by:**

Deirdre Byrne  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Outcome 01: Statement of Purpose

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose does not accurately reflect the services provided in the centre.

There were gaps in the information required by Schedule 1 of the Regulations to be included in the statement of purpose.

Action Required:
Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.
Please state the actions you have taken or are planning to take:
A review of the statement of purpose to be completed to:
1. Reassess the admission criteria for residents. (Complete)

2. Reflect the dependency level of care to residents that QPC provide. (Complete)

3. Include the therapeutic services provided by QPC. (Complete)

4. Review of the statement of purpose on an annual basis to ensure it is line with the practices of QPC. (Ongoing)

Proposed Timescale: 29/08/2014

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The system of review of residents safety and quality of care required improvement.

Action Required:
Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:
1. An audit system shall be developed to review the resident’s safety and quality of care provided by QPC. (05/09/2014)

2. Results from all audits on resident care plans to be communicated to staff at weekly meetings. (Ongoing)

3. Results from all audits on resident care plans to be communicated to management meetings monthly. (Ongoing)

4. All audit results to be an agenda item on management meetings and actions to be minuted. (Ongoing)

5. The actions carried out and completed arising from management and advisory council meetings to be documented and communicated to staff and residents. (Ongoing)

Proposed Timescale: 05/09/2014
**Outcome 03: Information for residents**

**Theme:**
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The residents guide required revision to include the terms and conditions.

**Action Required:**
Under Regulation 20(2)(b) you are required to: Prepare a guide in respect of the designated centre which includes the terms and conditions relating to residence in the centre.

**Please state the actions you have taken or are planning to take:**
1. The terms and conditions of the residents in QPC shall be reviewed by management and updated and documented in the residents guide. (05/09/2014)

2. All residents / representatives to be given a revised copy of the residents guide. (26/09/2014)

3. Residents guide to be an agenda item at the residents committee to communicate the changes to the resident guide. (next scheduled residents meeting in September)

**Proposed Timescale:** 19/09/2014

**Theme:**
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were gaps in the mandatory information required in the contract of care.

**Action Required:**
Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

**Please state the actions you have taken or are planning to take:**
1. Contact all external services providing a service to QPC to obtain prices which will be an additional cost to residents. (05/09/2014)

2. A review of the resident guide to include the costs of additional services provided by QPC. (05/09/2014)

3. All residents / representatives to be given a revised copy of the residents guide. (26/09/2014)
1. To be on the agenda at the next resident committee meeting the changes to the resident guide. (next scheduled residents meeting in September)

Proposed Timescale: 26/09/2014

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all policies required by Schedule 5 were maintained.
Not all operational policies and procedures for the centre guided practice.

Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
1. All policies and procedures required by Schedule 5 to be reviewed and updated and implemented to reflect best practices in QPC. (26/09/2014)

2. A review of the restraint policy and procedure shall be completed to reflect the practises in QPC and implemented. Education and training shall be provided to all staff to ensure knowledge and understanding of policy and procedure. (26/09/2014)

3. A review of the falls policy and procedure shall be completed to provide guidance to staff post fall in QPC and to implement the policy and procedure. Education and training shall be provided to all staff to ensure knowledge and understanding of policy and procedure. (26/09/2014)

4. An education session and training on Schedule 5 policies and procedures shall be scheduled to ensure all staff are have a knowledge and understanding of best practice. (26/09/2014)

5. The Director of Nursing shall monitor compliance with Schedule 5 policies and procedures on a monthly to ensure all staff are adhering to the policy. (Ongoing)

Proposed Timescale: 26/09/2014

Theme:
Governance, Leadership and Management
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Training records were not accurately maintained.

Action Required:
Under Regulation 21(5) you are required to: Retain the records set out in paragraphs (7) and (8) of Schedule 4 for a period of not less than 7 years from the date of their making.

Please state the actions you have taken or are planning to take:
1. All staff training records to be updated in conjunction when staff receive training, to include date received training and date training due. (26/09/2014)

2. All records to be maintained in a format that is easily readable and accessible. (Ongoing)

Proposed Timescale: 26/09/2014

Outcome 07: 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:
Improvements were required to ensure staff were equipped with the skill to manage behaviour that is challenging.

Action Required:
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

Please state the actions you have taken or are planning to take:
1. Provide external training on the management of behaviour that challenges to ensure that staff have a complete knowledge and understanding of best practice. (Complete)

2. Complete all assessments (Cohen-Mansfield) on residents that have behaviour that challenges. (26/09/2014)

3. Review care plans to ensure they guide care on the management of behaviour that challenges e.g. to include triggers and strategies to de-escalate behaviour that challenges are documented. (26/09/2014)

4. An education session on behaviour that challenges shall be scheduled for all staff to ensure staff have a knowledge and understanding of best practice. (26/09/2014)

1. The Director of Nursing and Clinical Nurse Manager shall regularly review all staff’s
understanding and knowledge regarding behaviour that challenges. (Ongoing)

Proposed Timescale: 26/09/2014

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management of restraint required improvement.

Action Required:
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

Please state the actions you have taken or are planning to take:
1. A review of the restraint policy and procedure to be carried out to reflect the practices carried out with QPC and they are in line with best practice. (26/09/2014)

2. Provide training on restraint for all staff to ensure that staff have a complete knowledge and understanding of best practice. (26/09/2014)

3. Ensure all assessments are completed where restraint is used (bedrails, lap belts) on a resident and is in line with the restraint policy and procedure and best practice. (26/09/2014)

4. Provide education and information sessions to the residents who are currently using lap belts and or bedrails. (17/10/2014)

5. Ensure consent is documented from residents or next of kin before the use of any restraints, unless in an emergency situation. (Ongoing)

6. Audit to be completed on a monthly basis by the DON to ensure compliance with best practice. (Ongoing)

7. All audit results to be presented to staff and management on restraint audits. (Ongoing)

Proposed Timescale: 17/09/2014

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The management of behaviours that are challenging required improvement.
**Action Required:**
Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

**Please state the actions you have taken or are planning to take:**
1. A review of the management of behaviour that challenges policy and procedure to ensure it guides staff and is in line with practice and the national policy. (26/09/2014)

2. Complete all assessments (Cohen-Mansfield) on residents that have behaviour that challenges. (26/09/2014)

3. Review care plans to ensure they guide care on the management of behaviour that challenges e.g. to include triggers and strategies to de-escalate behaviour that challenges are documented. (26/09/2014)

4. Provide an education session and training on behaviour that challenges shall be scheduled for all staff to ensure staff have a knowledge and understanding of best practice. (Complete)

5. The Director of Nursing and Clinical Nurse Manager shall regularly review all staff’s understanding and knowledge regarding behaviour that challenges. (Ongoing)

**Proposed Timescale: 26/09/2014**

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The person in charge and senior management were not fully clear of the centres policy and procedures to follow in the investigation of an allegation of abuse.

**Action Required:**
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

**Please state the actions you have taken or are planning to take:**
1. A review of responding to allegations of abuse policy and procedure to clarify the line of investigation. (16/09/2014)

2. Clarify whom would be involved in the investigation team and at what stage. (16/09/2014)

3. Clarify the stages involved in the investigation of an alleged abuse incident. (16/09/2014)
4. Communicate to all staff the process of an investigation in an allegation of abuse and the persons involved in the investigation. (26/09/2014)

5. Communicate to all residents and family members the process of an investigation in an allegation of abuse and the persons involved in the investigation. (03/10/2014)

6. Provide an education session and training on the detection and prevention of abuse shall be scheduled for all staff to ensure staff have a robust knowledge and understanding on the detection and prevention of abuse. (26/09/2014)

**Proposed Timescale:** 03/10/2014

---

**Outcome 08: 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:**
A number of areas of risk had not been identified or assessed as outlined in the inspection report.

There was an inadequate system in place to ensure that comprehensive, individualised risk assessments were completed for residents that smoked.

**Action Required:**
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

**Please state the actions you have taken or are planning to take:**
1. Ensure all new residents who smoke been admitted to QPC are risk assessed at the time of admission. (Ongoing)

2. Develop an audit schedule to ensure the ongoing management of all individualised risk assessments for residents who smoke are currently updated and assessed. (26/09/2014)

3. Communicate to staff and management the identification of any new risks within the centre. (Ongoing)

4. Risk assessments to be carried out on all smoking areas. (19/09/2014)

5. Ensure all control measures have been identified to manage all risks identified within the centre related to residents who smoke. (24/10/2014)
Proposed Timescale: 26/09/2014

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The actions or measures in place to control risks identified were not outlined.

Action Required:
Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
1. A review of the risk management policy to ensure compliance with regulations, to include measures and actions in place to control risks such as abuse, absconsion or self-harm. (16/09/2014)

2. Provide training to all staff on risk management to ensure that staff have a complete knowledge and understanding of the practices within QPC. (26/09/2014)

3. Update all staff and management of all current control measures that are in operation in QPC. (26/09/2014)

4. Sluice rooms to be fitted with a locked keypad. (Completed)

5. Internal and external smoking areas to be risk assessed and control measures to be put in place. (15/09/2014)

6. Ensure that a designated smoking facility away from the entrance of the centre will be provided. (31/10/14)

7. Ensure that broken panes of glass will be disposed from the centre. (Completed)

8. Fallen wall to be secured and rebuilt to ensure the safety of all residents. (11/09/14)

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:
The arrangements in place for the management of adverse events involving residents required improvement.

Action Required:
Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy
set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
1. Management to review of the risk management policy to ensure it guides practice for management and staff. (16/09/2014)

2. Director of Nursing to develop an audit schedule to ensure the update of individualised resident assessments are currently assessed and updated. (26/09/2014)

3. Provide training to all staff on the management of identification, recording, investigation and learning from serious incidents or adverse events involving residents within QPC (26/09/2014)

4. Ensure all control measures have been identified to manage all risks identified with the centre. (26/09/2014)

5. The Director of Nursing and Clinical Nurse Manager shall regularly review all staff’s understanding and knowledge of risk management. (Ongoing)

6. The Director of Nursing shall identify learning outcomes from serious incidents or adverse events involving residents and provide education and information to all staff. (Ongoing)

7. The Director of Nursing shall identify learning outcomes from serious incidents or adverse events involving residents and provide education and information to all residents and family members. (Ongoing)

Proposed Timescale: 26/09/2014

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy did not outline the measures in place to manage the risk of abuse.

Action Required:
Under Regulation 26(1)(c)(i) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.

Please state the actions you have taken or are planning to take:
1. Management to review of the protection of resident from abuse and responding to allegations of abuse policy and procedure to ensure it guides practice. (16/09/2014)

2. Provide training to all staff on the management of abuse, to ensure that staff have a complete knowledge and understanding of best practices. (26/09/2014)
3. The Director of Nursing and Clinical Nurse Manager shall regularly review all staff's understanding and knowledge of the signs of abuse and the management of abuse. (Ongoing)

**Proposed Timescale:** 26/09/2014  
**Theme:** Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The policy did not outline the measures in place to manage the risk of residents elopement.

**Action Required:**  
Under Regulation 26(1)(c)(ii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.

**Please state the actions you have taken or are planning to take:**  
1. Management to review of absconsion policy and procedure to ensure it guides practice to management and staff. (16/09/2014)  
2. Provide training to all staff on resident absconsion, to ensure that staff have a complete knowledge and understanding in the situation where a resident absconds. (26/09/2014)  
3. The Director of Nursing and Clinical Nurse Manager shall regularly review all staff's understanding and knowledge what to do in the situation where a resident absconds. (Ongoing)

**Proposed Timescale:** 26/09/2014  
**Theme:** Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The policy did not outline the measures in place to manage the risk of accidental injury in the centre.

**Action Required:**  
Under Regulation 26(1)(c)(iii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.
Please state the actions you have taken or are planning to take:
1. Management to review of the health and safety policy and procedure to ensure it is in line with regulations. (16/09/2014)

2. Ensure all risks have been identified and control measures have been put in place. (26/09/2014)

3. Develop an audit schedule to ensure all areas are regularly assessed. (26/09/2014)

4. Communicate to staff, residents and family the identification of any new hazard / risk identified and control measures to be put in place. (Ongoing)

**Proposed Timescale:** 26/09/2014

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy did not outline the measures in place to manage the risk of aggression.

**Action Required:**
Under Regulation 26(1)(c)(iv) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.

Please state the actions you have taken or are planning to take:
1. A review of the risk management policy to ensure it guides practice in the management of aggression. (16/09/2014)

2. Provide training to all staff on the management of aggression from residents or family members. (Complete)

3. The Director of Nursing and Clinical Nurse Manager shall regularly review all staff's understanding and knowledge of the management of aggression. (Ongoing)

**Proposed Timescale:** 26/09/2014

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy did not outline the measures in place to manage the risk of self harm.

**Action Required:**
Under Regulation 26(1)(c)(v) you are required to: Ensure that the risk management
policy set out in Schedule 5 includes the measures and actions in place to control self-harm.

Please state the actions you have taken or are planning to take:
1. A review of Meeting the Needs of Residents at Risk of Self Harm Policy and Procedure to ensure it guides practice for staff. (16/09/2014)
2. Provide training to all staff on the management of self-harm. (26/09/2014)
3. The Director of Nursing and Clinical Nurse Manager shall regularly review all staff’s understanding and knowledge of the management of self-harm. (Ongoing)

Proposed Timescale: 26/09/2014

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were inadequate records maintained of the fire drills that took place in the centre.

Action Required:
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
1. Learning outcomes identified from fire drills and documented and communicated to staff and residents (30/09/2014)

Proposed Timescale: 30/09/2014

Outcome 09: Medication Management

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Medication practices were not consistently carried out in line with best practice guidelines and the centre’s policy.

Action Required:
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident.
concerned and in accordance with any advice provided by that resident’s pharmacist regarding the appropriate use of the product.

**Please state the actions you have taken or are planning to take:**
1. All Staff to receive medication management training to ensure they have a clear knowledge and understanding of the best practices in medication administration. (26/09/2014)

2. Director of Nursing to complete regular audits to ensure compliance with best practice. (Ongoing)

3. Audit results to be presented to the management team and to all staff when completed. (Ongoing)

4. Identify learning outcomes from audit results and action all learning outcomes identified and communicate to staff. (Ongoing)

**Proposed Timescale: 26/09/2014**

---

**Outcome 11: Health and Social Care Needs**

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Care plans were not consistently reviewed following an incident or change in circumstances to reflect the residents most up-to-date care needs

**Action Required:**
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident’s family.

**Please state the actions you have taken or are planning to take:**
1. Training to be provided to all staff on care plans to ensure they have a clear knowledge and understanding of the requirements required of them in the updating of care plans. (26/09/2014)

2. Director of Nursing to carry out audits on care plans to ensure staff are updating care plans following an incident or change in circumstance in residents. (Ongoing)

3. Communicate the results of the audit to management and to all staff. (Ongoing)

4. Develop an audit schedule to ensure all resident care plans are reviewed by the Director of Nursing on a monthly basis. (Ongoing)
5. Director of Nursing to review two care plans daily, to commence by the 15/09/2014 and on an ongoing basis to ensure compliance with the care plan development and implementation policy and procedure. (15/09/2014)

6. Director of Nursing to review six care plans monthly to ensure compliance with the care plan development and implementation policy and procedure. (31/10/2014)

**Proposed Timescale:** 31/10/2014

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were improvements required in the managements of falls and wound care.

**Action Required:**
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnámhseachais.

**Please state the actions you have taken or are planning to take:**
1. A review of the management of falls to ensure it guides practice for staff post fall of a resident. (16/09/2014)

2. A review of the management of wound care policy and procedure to ensure it guides practice to all staff in the management of wounds. (16/09/2014)

3. Provide training and education to all staff to ensure they have a clear understanding on the management of falls and wound care. (26/09/2014)

4. Director of Nursing or Clinical Nurse Manager to carry out an audit for pressure relieving mattresses to ensure that they are at the correct setting for the residents weight in accordance with the manufacturing guidelines. (12/09/2014)

5. Director of Nursing to carry out audits on care plans to ensure staff are updating care plans following an incident or change in circumstance in residents. (Ongoing)

6. Communicate results of audits to management and to all staff. (Ongoing)

7. Identify learning outcomes from audits and action all learnings identified. (Ongoing)

**Proposed Timescale:** 16/09/2014

**Outcome 12: Safe and Suitable Premises**
Theme: Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Access to two en-suite showers was by a step which may not meet the needs of all residents.

Action Required:
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:
1. Carry out immediate risk assessment on residents currently using en-suite showers accessed by a step to ensure they are not at risk. (26/09/2014)
2. Carry out maintenance to showers to remove step and replace it with a ramp to ensure the shower is level with the floor therefore residents will not be required to step into the shower. (31/10/2014)
3. Provide education and awareness to residents who are using en-suite showers with step access. (26/09/2014)

Proposed Timescale: 26/09/2014

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:
The records of complaints did not include the investigation carried out, action taken and whether the residents was satisfied with the outcome.

Action Required:
Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident’s individual care plan.

Please state the actions you have taken or are planning to take:
1. All complaints recorded shall have documented evidence of the actions carried out in local resolution with the resident / family / staff. (30/09/2014)
2. Provide evidence to management on a monthly basis of all complaints / incidents recorded and the actions completed in the investigation. (Ongoing)
Proposed Timescale: 30/09/2014

**Outcome 17: Residents' clothing and personal property and possessions**

**Theme:**
Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Records of property were not in place for all residents.

**Action Required:**
Under Regulation 12 you are required to: Ensure that each resident has access to and retains control over his or her personal property, possessions and finances.

**Please state the actions you have taken or are planning to take:**
1. All residents’ personal property and possessions shall be recorded at time of admission and kept up to date. (26/09/2014)

2. All new residents admitted to the centre shall have an inventory completed before admission. (Ongoing)

3. Administration to complete an audit of resident personal property and possessions on a quarterly basis. (Ongoing)

4. Results shall be presented to management team on a quarterly basis. (Ongoing)

Proposed Timescale: 26/09/2014

**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The staffing skill mix required review.

**Action Required:**
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**
1. Review staff skill mix based on the dependency levels of the residents, assessed needs of the residents, the qualifications of all staff, the size of the centre and layout of
2. Management to discuss with the residents at the resident committee to ensure residents are satisfied with the nursing staffing levels. (Next resident committee meeting)

<table>
<thead>
<tr>
<th>Proposed Timescale: 30/09/2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Workforce</td>
</tr>
<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>An Garda Síochána vetting was not in place for all external service providers.</td>
</tr>
<tr>
<td><strong>Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 30(c) you are required to: Provide a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 for people involved on a voluntary basis with the designated centre.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>1. All staff (internal and external) to be Garda Vetted, prior to commencing work e.g. security guards (12/09/2014)</td>
</tr>
<tr>
<td>2. Administration to audit all staff files including all external and volunteers to ensure compliance with regulation 30(c) (12/09/2014)</td>
</tr>
</tbody>
</table>

| Proposed Timescale: 12/09/2014 |