<table>
<thead>
<tr>
<th><strong>Centre name:</strong></th>
<th>Queen of Peace Centre</th>
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<tbody>
<tr>
<td><strong>Centre ID:</strong></td>
<td>OSV-0000085</td>
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<tr>
<td><strong>Centre address:</strong></td>
<td>6-8 Garville Avenue, Rathgar, Dublin 6.</td>
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<tr>
<td><strong>Telephone number:</strong></td>
<td>01 497 5381</td>
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<tr>
<td><strong>Email address:</strong></td>
<td><a href="mailto:spcqueen@eircom.net">spcqueen@eircom.net</a></td>
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<tr>
<td><strong>Type of centre:</strong></td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<tr>
<td><strong>Registered provider:</strong></td>
<td>Sisters of St Paul de Chartres</td>
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<tr>
<td><strong>Provider Nominee:</strong></td>
<td>Brian Lee</td>
</tr>
<tr>
<td><strong>Lead inspector:</strong></td>
<td>Deirdre Byrne</td>
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<tr>
<td><strong>Support inspector(s):</strong></td>
<td>Gearoid Harrahill</td>
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<tr>
<td><strong>Type of inspection</strong></td>
<td>Unannounced</td>
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<tr>
<td><strong>Number of residents on the date of inspection:</strong></td>
<td>43</td>
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<tr>
<td><strong>Number of vacancies on the date of inspection:</strong></td>
<td>2</td>
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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, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 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: 15 September 2015 08:00  
To: 15 September 2015 19:00

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 03: Information for residents</td>
<td>Compliant</td>
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<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
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<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Non Compliant - Moderate</td>
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Summary of findings from this inspection
This inspection took place to assess ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards of Residential Care Settings for Older People in Ireland 2009. Inspectors also followed up on areas of non compliance identified at the previous inspection which took place on the 11 and 12 February 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. Inspectors met the provider nominee (who will be referred to as the provider for the report) at the inspection, who also attended the opening and feedback meeting. The person in charge and assistant director of nursing (ADON) also were present during the inspection, and fully cooperated with the inspection.

Inspector's found that there were suitable governance arrangements in place.
Inspector observed staff who interacted with residents in a kind, dignified and respectful manner. The staff in turn were knowledgeable of the health care needs of residents. There were systems in place for the prevention of abuse and there were good practices in the management of restrictive practices which were clearly documented and investigated. The staffing levels and skill mix were adequate to meet the assessed needs of residents.

However, a number of improvements were identified, and these related to the management of behaviours that challenge, the on-going monitoring of the quality of care, and completion of an annual report of the quality and safety of care. The documentation of care plans required improvement to guide staff practice. An area of improvement in relation to medication management, the completion of fire drill records and an aspect of the premises were also identified.

The 27 actions from the previous inspection were reviewed: two had not been addressed and three were in progress. These and all other matters are outlined in the report and Action plan at the end of the report.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

**Outcome 01: Statement of Purpose**

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

**Theme:**

Governance, Leadership and Management

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

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

**Findings:**

Inspectors were satisfied that there was an up-to-date Statement of Purpose that met the requirements of the Regulation and the criteria of Schedule 1.

Inspectors reviewed the Statement of Purpose (SoP) for the centre which was dated July 2015. It outlined the aims, objectives and ethos of the designated centre. The SoP contained all information required by the Regulations, and actions from the previous inspection had been addressed. The information was detailed and specific to the centre and its services, and reflected in the operation of the service and in policies reviewed as part of the inspection.

**Judgment:**

Compliant

**Outcome 02: Governance and Management**

*The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.*

**Theme:**

Governance, Leadership and Management

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

Some action(s) required from the previous inspection were not satisfactorily implemented.
Findings:
Inspectors found there was a clearly defined management structure that outlined the lines of authority and accountability in the centre. However, improvements were identified regarding the ongoing review of the quality and safety of life of residents and completion of an annual report as per the Regulations.

The provider had ensured there were adequate governance arrangements in place. The person in charge who was based full time in centre and reported to the provider nominee. An advisory council met on a monthly basis and the minutes of recent meetings were read. The provider and person in charge who attended the meetings presented an update on the residents' needs, incidents, staffing and the day to day operation of the centre. The provider and the person were also in regular in charge were and met on an informal basis.

There were systems in place for the management of the centre. Inspectors read the minutes of general staff meetings that took place on a monthly basis. A range of topics were discussed in the minutes read. For example, incidents, staff issues, residents feedback and risk management. It was noted that the minutes of the residents' committee meetings were also discussed. This was brought to the attention of the provider and person in charge, who are aware that matters raised at such meeting are to be treated with the upmost confidentiality and actioned appropriately without identifying individuals.

There were nurse meetings held to review clinical risk. However, these meetings had only been held twice, in January and August 2015. In between meetings the person in charge issued regular memos to nurses. Overall, inspectors could not find what clinical reviews had taken place or how decisions were made in relation to the on-going review of the residents and clinical issues, risks and supervision of residents in the centre.

There were systems in place to monitor the quality and safety of care. Inspectors reviewed audits of care plans, staffing files, dementia and wound care which had last been carried out in January and February 2015. However, there had been no audits of these areas completed since. Therefore it could not be ascertained what ongoing improvements had taken place. Audits completed were limited to a monthly review of the health care assessments completed for the residents. The person in charge collected a range of key performance indicators each month for example, falls, use of restraint, psychotropic medications, pressure sores and episodes of behaviour that challenge. There was evidence of analysis of the falls, but not of the other incidents. The person in charge said they had little or no incidents in the other categories. Inspectors saw evidence that falls were discussed at the advisory council and the general staff meetings.

The provider had not developed an annual report on the overall review of the safety and quality of care of residents as required by the Regulations.

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

**Findings:**
Inspectors were satisfied that residents were provided with a guide to the centre and residents were provided with had a written contract of care on their admission to the centre. The actions from the previous inspection were addressed.

The residents guide was detailed and contained the information required by regulations on the services, terms and conditions of the residents’ care.

Inspectors reviewed a sample of the residents’ contracts of care. They included the services and equipment provided and the duties and responsibilities of the staff. The responsibilities of the residents were also clearly outlined. The fees were identified, along with a list of additional services not covered by the fees. The contract included a detailed price list of the charges to be incurred by residents for the services.

**Judgment:**
Compliant

### 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):**
No actions were required from the previous inspection.

**Findings:**
Inspectors were satisfied that the centre was managed by a suitably qualified and experienced person with accountably and responsibility for the service.

The person in charge was a registered nurse who had the relevant length of experience required by the Regulations. She demonstrated adequate knowledge of the Regulations, and was aware of her requirements therein. The person in charge held regular meetings...
with staff, and the minutes of these meeting were read by inspectors and outlined a range of issues discussed.

Inspectors found the person in charge was familiar with the residents' health and social care needs, and was observed interacting with residents during the inspection. The residents in turn were very familiar with her and told inspectors that she was always stopping by to talk to them. One resident told inspectors the person in charge welcomed here when she arrived in the centre.

The person in charge participated in ongoing professional development by attending seminar and courses on a range of topics. She had completed training in mandatory areas.

There were satisfactory deputising arrangements with the person in charge supported in her role by an assistant director of nursing (ADON).

**Judgment:**
Compliant

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

**Findings:**
Inspectors found the records, policies and procedures required by the Regulations were in place. This was the only component of this Outcome reviewed at the inspection. The actions from the previous inspection were also completed.

Inspectors found the the records required to be maintained by Regulations were stored in a secure place and easy to retrieve. However, an aspect of records required to be kept for residents required improvement. For example, as required "PRN" medications were administered without the maximum prescribed dose or general practitioner signature consistently provided. This is discussed in outcome 12.

All polices required to be maintained by Schedule 5 were in place. While they were
maintained in a manner to ensure accuracy, inspectors found the most up-to-date versions were not provided on request. After the inspection all up-to-date policies were submitted to the Authority. The person in charge assured inspectors these were now fully available and stored in an easy to retrieve location.

Judgment:
Non Compliant - Moderate

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 and the provider promoted a restraint free environment. However, the management of residents with responsive behaviours required improvement. The actions from the previous inspection had not been fully completed.

There was a policy in place to guide staff practice on behaviours that challenge. However, it was not implemented in practice as staff practices observed by inspectors was not in line with policy and best practice. For example, incidents involving one resident were being informally reported by staff in a note book. The incidents recorded had not been reviewed or analysed to identify any pattern, trends or triggers in their behaviours. There was no documented rationale for the note book and no formal procedure to guide staff in completing reports. Inspectors read evidence based tools such as the ABC (antecedent behaviour consequence) chart that were used to document some behaviours. However, the reports were not clear, contained lengthy dialogue with the resident and were not reviewed after each incident. The care plan for the behaviours was reviewed and while it contained some information to guide staff, it did not fully guide practice for example, the triggers to the behaviours, de-escalation techniques or the procedures staff should follow during or after an incident. Inspectors spoke to staff who could describe residents behaviours that challenged but were unsure of what interventions they should follow. This was discussed at feedback with the person in charge and provider who assured inspectors appropriate action would be taken.

Inspectors found staff had been provided with training in the management of behaviours that challenge since the last inspection. However, as outlined above it was
not fully utilised in practice. In turn, staff were unsure how to manage the behaviours and the incidents with the residents. This had been an issue at the previous inspection and had not been fully addressed.

There had been no allegations of abuse in the centre since the last inspection. A suite of policies on the protection of vulnerable adults guided staff practice and incorporated the national HSE policy and procedures on the protection of vulnerable adults. The policies included information on the types and indicators of abuse. They outlined the procedures to follow in the event of an allegation of abuse. Inspectors found the person in charge and senior nursing staff were knowledgeable of how they would investigate an allegation of abuse. This had been an action from the previous inspection and was completed.

Records were read that confirmed all staff had received training in the protection of vulnerable adults, and regular training was taking place. Staff spoken to were knowledgeable of the types of abuse and the reporting arrangements in place.

There were suitable arrangements were in place to safeguard residents' finances. Inspectors reviewed a sample of residents monies that were held in safeguarding by the centre. There were records of cash transactions held for each resident and these were signed off by two staff. There were two designated staff authorised to make transactions on residents behalf.

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

There was a policy on restrictive practices reviewed by inspectors. It had been updated since the previous inspection and it now included the current arrangements in place for the use of bedrails, lap-belts and wandering tags. Inspectors found a low number of residents required physical restraint. There were seven residents using bedrails and three using lap belts. There was evidence of bedrails and lap-belts being routinely risk assessed, and care plans were put in place to guide their use as per 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. An area of improvements in relation to the ongoing management of risk and an area of fire safety was identified.

Inspectors found the provider ensured the centre was protected from the spread of fire and adequate fire precautions were in place. Practices around the use of fire doors required improvement. However, this was addressed by the provider promptly during the inspection.

Inspectors read reports of fire drills that confirmed they were completed every six months. They included the staff in attendance and the length of time the drill took but the outcome from each was not described. A separate sheet shown to inspectors that outlined a detailed review of a fire drill however, it was not dated so it could not be ascertained which drill it related to.

There were fire orders displayed throughout the centre. Service records showed that the emergency lighting and fire alarm system was serviced regularly and fire equipment was serviced annually. It was noted that the fire panels were in order and fire exits unobstructed. There were regular fire safety checks which included fire exits. The centre kept a detailed fire folder which kept record of all daily, weekly, monthly and annual checks and tests including fire alarms, emergency routes and fire equipment.

There were health, safety and risk management policies for the centre. The risk management policy met the requirements of the Regulations, and made reference to the management of specified risks. This was an action from the last inspection and it was addressed. The policy appeared to be implemented in practice and no areas of risk were identified by inspectors. There had been one health and safety committee meeting in the centre however, there was no formal system of reviewing or monitoring risk in the centre. For example, there were documented health and safety checks of risks identified and if they were being managed correctly.

There were three risk registers seen by inspectors: a health and safety risk register, a service and care provision risk register and a corporate risk register. The registers were reviewed by inspectors and each contained a range clinical and non clinical risk assessments, along with information on the controls measures to manage the risk.

The person in charge reviewed incidents and there was evidence of risk assessments completed for each. Inspectors found appropriate action was taken to address each incident and they were investigated in a timely manner. There was evidence of the learning or improvement to prevent these incidents from happening again.

The residents were encouraged to be actively mobile and were observed 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 and records read confirmed all staff had completed training. Inspectors found that there was safe floor covering and handrails throughout the centre and a passenger lift accessed each floor.
There were procedures in place for the management of adverse events involving residents and they included information on carrying out an investigation following a serious incident involving a resident. Inspectors discussed the procedures with the person in charge who outlined how she would investigate a serious incident.

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.

There were measures and policies in place to control and prevent infection. 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.

**Judgment:**
Non Compliant - Moderate

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**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 the designated centre had policies and procedures for medication management, and overall this outcome was compliant. An area of improvement regarding the implementation of the policy was identified. The actions from the previous inspection had been addressed.

A comprehensive medication management policy was seen by inspectors. Inspectors read completed prescription and administration records and overall they were in line with best practice guidelines. However, the administration of as required (PRN) medications requires improvement. For example, the PRN prescriptions reviewed were not consistently signed by a general practitioner and the maximum dose was not stated. This was not in line with the centres policy or professional guidelines. See Outcome 5 for details. This was discussed with the person in charge during the inspection.

There was written evidence that residents medications were reviewed every three-months. There were regular audits of the medication and prescription sheets along with staff practices, although the issues identified above had not been picked up by the audits.

There were procedures in place for the self administration of medication by residents. Inspectors discussed this with staff who described the procedures and the different
levels of self administration. A small number of residents administered their medications without supervision and clear criteria and agreements were documented regarding these arrangements.

Inspectors read reports of a small number medication errors that had occurred. An incident form was completed, which also included details of the investigation carried, actions that were taken and evidence of sharing of information with staff for learning purposes.

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 them to be correct.

Inspectors read records that confirmed all staff nurses involved in the administration of medications had undertaken training updates in best practice.

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

Findings:
Overall, inspectors found residents were regularly assessed for a range of health care needs with care plans developed where a risk was identified. However, the documentation of care plans required improvement. The actions from the previous inspection were fully addressed.

A sample of residents' care plans were reviewed during the inspection. The care plans were in an electronic format. Inspectors found residents were regularly assessed using evidenced based tools. There were care plans were developed where a need was identified. However, the documentation of some care plans required improvement as the plans did not consistently guide staff practice or reflect the good practices carried out by staff. For example, behaviours that challenge, wound care, diabetes and catheter care.
The person in charge promptly addressed this and later inspectors were shown updated diabetes and catheter care plans that contained detailed guidance.

Inspectors found the care plans were regularly reviewed and updated after a change in need or circumstance. The specific wishes or preferences of residents were described such as end of life care.

There was evidence that residents and their families were consulted with regarding their care. The person in charge invited all resident or their representative if required to attend a meeting to review the updated care plans. A list of the meetings held to date was read by the inspectors.

There were good practices in the management of residents' nutritional needs, the management of falls and the arrangements in place for wound care. As reported above there were regular review of residents' health care needs using evidence based assessments tools. These were completed every three months. Where an identified need arose, care plans were developed. The staff were knowledgeable of residents care needs and had also received training to enhance their practices and keep them up to date with best practice. There was evidence of referral to the relevant health professionals. Inspectors saw electronic nursing notes provided information on the treatment and condition of the residents.

There was regular access the services of a medical practitioner in the area, and many of the residents chose to retain their own general practitioner (GP). Inspectors saw evidence of regular review of residents' medical needs. There appropriate arrangements in place for on call out of hours and at weekends.

A range of external allied health professional services were available and included, physiotherapy, occupational therapy, chiropody, dietician, speech and language therapy. There were also referrals and appointments seen to take place with geriatrician and psychiatry service. Where recommendations were made by these professionals, they 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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Inspectors were satisfied that the design and layout of the centre was in line with the Statement of Purpose and met residents’ individual and collective needs.

The centre was kept clean, and was well maintained to a good standard of repair. The building was well lit, heated and ventilated, and was quiet and comfortable for residents. At the time of inspection, there was work being carried out in the garden. The wall that was collapsed during last inspection had been rebuilt, and a path was in the process of being extended for residents with mobility issues to navigate the garden. However, the works were not finished and the garden was not fully accessible to residents. Inspectors observed the garden area was poorly maintained as there was weed growth coming through the paving and equipment was stored here for example, unused catering shelving.

The centre was laid out over three floors, each accessed by a lift. The ground floor was accessed by a secure reception areas. There was catering kitchen, dining room, offices and visitors room. A large day room was on the first floor and a chapel on the second. There were two designated smoking areas.

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 en suite shower, wash-hand basin and toilet. There was sufficient number of toilets, bathrooms and showers to meet the needs of residents. There was also adequate communal and private space in which residents could receive visitors.

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. It was noted at the previous inspection that two ensuite showers required a step to access. This had been addressed and replaced with a gated wetroom space level with the rest of the floor.

Judgment:
Substantially Compliant
### 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 were satisfied that the provider and person in charge ensured there was a positive approach to the management of complaint and there were arrangements in place to act on and investigate each complaint.

There was a detailed complaints management policy in place which met the requirements of the regulations. The procedure through which residents can make complaints was on display in the main corridors of the centre and outlined the appeals process and the relevant contact details.

Residents told inspectors that they were aware of who to contact to make a complaint and that they would be comfortable doing so.

Verbal complaints were documented and kept together in a folder, along with a summary of complaints, the actions taken on foot of those complaints, the satisfaction of the complainant and learning in place for the staff going forward.

### Judgment:
Compliant

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### 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.

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### 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 the residents in the centre. However, the supervision of staff as required by Regulations required improvements.

There were two nurses on duty at all times. The action from the previous inspection regarding two nurses in the centre from 3.30pm to 7.45 am was followed up. While the person in charge had increased the staff on duty at this time and two additional health care assistants rostered between 4pm and 10pm, no additional nurses were assigned. However, the ADON was rostered on some days from 11am to 7pm which increased nurses to three at certain times of the week. The staff reported they were satisfied with the staff levels. Inspectors did not observe any negative outcomes for the residents during the inspection.

There was a planned and actual staff rota that clearly identified shift times, and the location each staff member was assigned to. It included the times of the person in charge. The roster indicated the staff member who was the designated fire warden for that shift.

The centre’s recruitment policy sufficiently outlined the process of advertising, screening, interviewing and hiring staff. A sample of staff files were reviewed by inspectors, and contained the documentation required by Schedule 2 of the Regulations. The person in charge maintained a folder of nurses registration details for An Bord Altranais agus Cnaimhseachais na hEireann for 2015.

Inspectors saw appraisals had been completed for staff. However, there was no formal supervision of staff in the centre which is a requirement of the Regulations.

The person in charge ensured there was education and training available to staff including mandatory. A training matrix including all staff employed at the centre was reviewed by inspectors. All staff, including maintenance, kitchen and administrative staff completed up-to-date training in the moving and handling of resident, prevention of abuse, fire safety. There was medication management training for nurses. Staff also received training to meet the health care needs of residents, for example, dementia, cardio-pulmonary resuscitation (CPR), care planning, food and nutrition, and continence promotion. There was confirmation of staff attendance at each session and signed attendance sheets and certificates were held in the training folder.

Inspectors were satisfied that staff were competent to deliver care and support to residents. Staff were knowledgeable of the key policies and procedures for the centre (with an area of improvement identified in relation to the management of behaviours that challenge in outcome 7). Residents who spoke to inspectors praised the staff and how well they were looked after and made feel safe. Inspectors observed staff being friendly and respectful to residents, promptly answering the call bell for each room, knocking before entering bedrooms and working quietly in the morning as many residents slept in.

**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
Provider's response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Queen of Peace Centre</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000085</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>15/09/2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>12/10/2015</td>
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</tbody>
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Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure 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.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

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:
There is no annual review of the quality and safety of care delivered to the residents.

1. 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.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
1. An annual quality review for 2015 shall be conducted against the national standards and business intelligence, e.g. incidents, audits, complaints and KPIs. A report detailing the outcome of this review shall be produced and shared with staff and residents. A quality improvement plan will also be part of the report to progress improvement opportunities.

Proposed Timescale: 30/11/2015

Theme:
Governance, Leadership and Management

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

2. Action Required:
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
1. PIC/DON will formally audit care plans on a bi-monthly basis to ensure care plans and assessments are up to date and reflects the care required by the residents in a person-centered approach.
2. All incidents will be analysed further where trends arise and learning extracted to make improvements and enhance learning, e.g. behaviours that challenge

Proposed Timescale: 15.10.15 and ongoing

Proposed Timescale: 15/10/2015

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:
The completion of medication administration records required improvement.

3. Action Required:
Under Regulation 21(3) you are required to: Retain the records set out in Schedule 3 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.
Please state the actions you have taken or are planning to take:
1. All PRN medications have been prescribed and signed by the GP who prescribed the medication. These are also recorded on the Medication Administration Record (MAR) to give direction to the nurses who administer the medication to the residents including the maximum dose of the Lactulose medication. DON will ensure that the maximum dose for Lactulose will be written on the resident’s prescription sheet every time it is prescribed.

Proposed Timescale: 25.08.15 and ongoing

Proposed Timescale: 25/08/2015

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:
Further skills training is required to ensure staff are knowledgeable of how to respond to behaviours that challenge.

4. 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. Training on dementia and behaviours that are challenging has been organised by the PIC/DON on 12th and 17th of November 2015 which will be attended by all staff in all departments.

Proposed Timescale: 17/11/2015

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 challenge requires improvement.

5. 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. Training on management of behaviours that challenge has been scheduled for all the staff on 12th and 17th of November 2015.
2. Specific concerns raised during the inspection shall be addressed through further assessment by their GP, social worker and Geriatrician. Advice from these consultations will be implemented as appropriate.
3. Care Plans on Behaviours that are challenging will be revised as per advised from the training.

**Proposed Timescale:** 17/11/2015

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**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:**
The practice of using wedges to hold open fire doors in residents bedrooms required attention.

**6. Action Required:**
Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

1. The PIC/DON liaised with a Fire Consultant who has made a proposal on how to ensure that bedroom doors are not prevented from closing when the fire alarm is activated. “Fire swing” door closers will replace the existing door closer and will be wired to the fire alarm. The term “free swing” means the doors can be positioned in any position and will close on activation of the fire alarm.
2. As per advice by the fire consultant, in the intervening period it is proposed that at night time (2000 -0800) as many doors as possible will be shut. Where residents prefer their doors not to be fully closed, wedges may be used to hold the doors in a position as close to closed as possible.
3. In the event of an emergency the wedges in the doors will be closed as a first priority. It is also noted that the premises is compartmented and sub-compartmented. Sub-compartment doors close on detection of fire; this has the effect of reducing the area of evacuation.

**Proposed Timescale:** 30/11/2015
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 reviewed did not consistently guide practice.

7. Action Required:
Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident’s admission to the designated centre.

Please state the actions you have taken or are planning to take:
1. All care plans have been reviewed and audited by the DON/PIC in detail and are all up to date. PIC will continue to review care plans on a monthly basis or more often as required.
2. Training will be provided to nursing staff regarding care plan development and maintenance.

Proposed Timescale: 15/11/2015

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:
The garden was not accessible to all residents.
The garden was not maintained in a good standard of repair.
Unused equipment was stored in the garden.

8. 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. The widening of the pathway in the garden has been completed to make the garden more accessible to all residents.
2. Weeds in the side garden have been removed. The areas in the garden with overgrown grass has been cut and will be maintained into good standard.
3. Unused equipment that was stored at the side of the garden has been removed.

Proposed Timescale: 31/10/2015
Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no formal system of staff supervision in the centre.

9. Action Required:
Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
1. Formal one to one meetings will be scheduled with all staff on a monthly basis with their line manager. These meetings will include development requirements, addressing concerns and other performance matters.

Proposed Timescale: from 12.10.2015

Proposed Timescale: 12/10/2015