<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St. Peter’s Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000122</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Sea Road, Castlebellingham, Louth</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>042 938 2106</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:stpeters@trintycare.ie">stpeters@trintycare.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Costern</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Keith Robinson</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Sonia McCague</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Siobhan Kennedy</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>39</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
</tr>
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</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, 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 following receipt of unsolicited information. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From: 13 January 2016 09:30  
To: 13 January 2016 18:30  
16 January 2016 07:00 16 January 2016 14:30

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
</tr>
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<tbody>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 10: Notification of Incidents</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Non Compliant - Major</td>
</tr>
</tbody>
</table>

Summary of findings from this inspection

This inspection was triggered and unannounced following receipt of a number of unsolicited pieces of information by the Authority that outlined significant issues of concern for the care and welfare of residents.

The inspection took place over two days and focused on specific areas and regulations within the outcomes reported.

On arrival to the centre the nurse in charge was informed of the purpose of the inspection.

Inspectors later met with the person in charge and other persons participating in the management of the centre, who were also informed of the purpose of the inspection.

Inspectors met and spoke with residents and interviewed a significant number of staff during this inspection.

While some issues outlined within the concerns received were not substantiated on
this inspection, many were substantiated resulting in non compliances with the Health Act 2007.

Inspectors found major non-compliances in seven of the eight outcomes inspected. Significant improvements were required in relation to the governance and management of adverse incidents and allegations, suspicions and reported abuse, training, skill mix and supervision of staff and of their understanding of required procedures and policies to protect residents from abuse or harm, mitigate risks and manage complaints.

Incident management and reporting, assessment and care planning, and recording practices also required improvement.

As a result of the overall inspection findings, the inspectors recommended that a further review was required by the provider of the quality and safety of care delivered to residents in the designated centre in consultation with staff, residents and their families. A copy of the quality review is to be made available to residents and to the Chief Inspector on completion.

Findings and areas for improvement are outlined in the body of this report and in the action plan at the end for response.
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):
No actions were required from the previous inspection.

Findings:
Improvements were required to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

While operational management arrangements were in place, deficiencies were found in relation to the management of incidents, concerns and allegations, and reporting systems within the designated centre.

There was a high turnover in nursing and care staff in the previous 12 months and a number of relief and or agency staff were working in the centre. Staff told inspectors that frequent changes within the staff team had attributed to difficulties in the delivery of consistent effective evidence based practices. Staff told inspectors that a request for additional staffing resources to meet the increased activity, supervision and dependency level of residents had been rejected.

Arrangements in place to support, develop and performance manage all members of the workforce required improvement to ensure the quality and safety of the services being delivered. Known and or identified risks had not been adequately managed to ensure sufficient or consistent resources and systems were in place.

As a result of the overall inspection findings, the inspectors recommended that a further review was required by the provider of the quality and safety of care delivered to residents in the designated centre in consultation with staff, residents and their families.

A copy of the quality review is to be made available to residents and to the Chief Inspector on completion.

Judgment:
Non Compliant - Major

**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:**
Records set out in Schedules 2, 3 and 4 were not kept in a designated centre and or available for inspection.

A record with details of any plan relating to a resident in respect of specialist health care following assessment and or case reviews was not maintained in the centre to demonstrate involvement, recommendations and or prescription of care plan.

The record of all incidents in which a resident suffers abuse or harm was not maintained. Records were not sufficiently completed to include the nature, date and time of incidents, whether medical treatment was required, considered or offered, the names of the persons who were respectively in charge of the designated centre and supervising the resident, and the names and contact details of any witnesses, the results of any investigation and the actions taken.

A record of all medication errors had not been recorded and or reported.

The record of all complaints made by residents or representatives or relatives of residents or by persons working at the designated centre, and the action taken by the registered provider in respect of any such complaint was not consistently maintained.

Operational procedures described and written policies set out in schedule 5 that included the prevention, detection and response to abuse, management of behaviours that challenged, risk management and the handling and investigation of complaints, had not been sufficiently and or consistently implemented in practice.

The policy in relation to the creation, access to, retention of and destruction of records required review. While records were held and kept in the designated centre, the key to access all records was not available in the centre at all times or available to all staff.
### 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):
No actions were required from the previous inspection.

### Findings:
While staff training in relation to behaviour that challenges had been provided, all staff had not attended training and some staff did not have sufficient up to date knowledge and skills, appropriate to their role, to respond to and manage behaviours that challenge.

Episodes of behaviours that challenge that posed a risk to residents had not been appropriately assessed, reported, responded to or managed. While recent improvements in relation to control measures in place were noted, all reasonable measures to protect residents from all forms of abuse were not sufficiently maintained or demonstrated.

Gaps were found in relation to the implementation of operational procedures and responsibilities, staff awareness, reporting arrangements, supervision and staff training that related to safeguarding vulnerable adults.

Practices found and information received demonstrate that all staff were not sufficiently trained or knowledgeable about the policy to ensure appropriate safeguarding measures were implemented.

All concerns or allegations of abuse had not been investigated and or reported in accordance with the policy and procedures described by management.

### Judgment:
Non Compliant - Major

### 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

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

**Findings:**
As outlined in other outcomes, operational polices and systems that included the identification, assessment and management of actual and potential risks had not been sufficiently implemented in practice to mitigate risks and or ensure adequate controls were in place.

Allegations and episodes of abusive and aggressive behaviour had not been sufficiently reported and assessed to ensure all risks were identified and investigated for sufficient measures and actions to control risks and or inform learning following all adverse incidents involving residents.

Infection control procedures had not been adequately or consistently maintained to ensure high standards in practice.

**Judgment:**
Non Compliant - Major

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**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

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

**Findings:**
Allegations, suspicions and reported abuse had not been notified to the authority or chief inspector, as required.

Allegations of staff misconduct had not been notified to the authority or chief inspector, as required.

**Judgment:**
Non Compliant - Major

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

**Findings:**
From a review of resident clinical records, inspectors found gaps in communications and incomplete records in parts.

A comprehensive assessment to inform the behavioural support plan of a resident had not been sufficiently maintained and communicated to all staff.

Care plans were not sufficiently informed by a comprehensive assessment that was reviewed and updated at suitable intervals to reflect changes and or events.

Gaps found in the clinical records and incident management or reporting did not demonstrate a high standard of evidence based nursing care in accordance with professional guidelines.

**Judgment:**
Non Compliant - Major

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

**Findings:**
A complaints procedure and a log was available in the centre. However, inspectors found all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint were not fully and properly maintained or recorded, and or distinct from a resident’s individual care records.
Judgment:
Non Compliant - Moderate

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

**Findings:**
Interviews were carried out with a significant number of staff for the purpose of establishing and gathering evidence in relation to anonymous unsolicited information received by the Authority. As a result, a review of staff numbers, skills mix and supervision arrangements were required.

As outlined in outcome 2, a high turnover of staff had negatively impacted on the skill mix of staff and the team dynamic. Staffing arrangements did not consistently ensure that the number and skill mix of staff was suitable and or sufficiently experienced and knowledgeable to meet the assessed needs and requirements of all residents.

An increased number of adverse events and serious incidents involving residents had occurred in the centre within previous months and a significant number of incidents had not been reported appropriately within the organisational structure.

Gaps were identified in staff training and supervision arrangements.

While the programme of training was ongoing, all staff had not had access to appropriate training relevant to meet all residents’ needs. All staff were not adequately trained in positive behaviour support and or managing behaviours that challenge including de-escalation and intervention techniques.

While management systems and arrangements were in place, they had not ensured all persons working in the centre were appropriately supervised, supported or developed to ensure the assessed needs of residents were maintained.

**Judgment:**
Non Compliant - Major
**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:**

Sonia McCague  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St. Peter's Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000122</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>13/01/2016 and 16/01/2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>19/02/2016</td>
</tr>
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</table>

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:
A number of relief and or agency staff were working in the centre as the result of a high turnover in nursing and care staff over the past 12 months.

Staff told inspectors that frequent changes within the staff team had attributed to difficulties in the delivery of care and effective practices developed by existing staff.
Staff told inspectors that a request for additional staffing resources to meet the

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
increased activity, supervision and dependency level of residents had been rejected.

1. **Action Required:**
Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

**Please state the actions you have taken or are planning to take:**
- Staffing levels have not changed as agreed per statement of purpose and within recommended levels. In 2015 staff hours were increased by 20 hours per week.
- Some staff members will always say there are not enough staff if asked.
- In line the majority of Irish nursing homes we were adversely affected by the lifting of the HSE recruitment embargo as nurses joined the HSE. However replacement staff that were employed met the legislative requirements and had a minimum of FETAC Level 5 training. In addition to this all staff was given a comprehensive induction / orientation to the services and this was generally on a one to one basis.
- In 2015 there was a total of 730 (12 hour) nurse registered shifts, we only used agency for 24.5 shifts or 3% of the total. In 2016 this will reduce further as nurses that have been recruited in 2015 receive their registration pins.
- We never used agency for carers as there are sufficient numbers.
- Call bell response audits are conducted by the Person In Charge to evaluate staffing resources as well to monitor effective delivery of care.
- A review of the dependency levels is conducted on a monthly basis and staffing levels are monitored and adjusted accordingly.

**Proposed Timescale:** February 2016, then Monthly & Ongoing

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**Proposed Timescale:** 29/02/2016

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Operational management deficiencies were found in relation to the management of incidents, concerns and allegations, and reporting systems within the designated centre.

2. **Action Required:**
Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

**Please state the actions you have taken or are planning to take:**
- The allegation of suspected resident to resident abuse made by a staff/ ex staff member that was subsequently proven unfounded was not fully investigated as per our policy and not reported to the authority. We have taken corrective action so this can no longer occur.
- There is a clearly defined management structure in place that identifies a supportive
structure for all service provisions

- The PIC is supported by the Clinical Operations Manager and Trinity Care Support office, that comprises of the Registered Provider, HR Director, Facilities Manager, Finance Manager, Catering Manager and Administration

- There are fortnightly clinical governance management meetings held in the nursing home

- There will be additional support provided to the PIC by the Clinical Operations Manager

**Proposed Timescale:** 19/02/2016

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Arrangements in place to support, develop and performance manage all members of the workforce required improvement to ensure the quality and safety of the services being delivered.

Known and or identified risks had not been adequately managed to ensure sufficient or consistent resources and systems were in place.

3. **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:**
- The following systems are currently in place
  - Daily communications
  - Weekly reports
  - Fortnightly management meetings
  - Monthly DON/ operations management meetings
  - Quarterly audits conducted on the home and verified by the operations manager
  - Performance appraisals completed annually
  - Annual review of KPI’s
- All audit systems will be reviewed to ensure support development is in place and to identify areas of learning

Proposed Timescale: ongoing

**Proposed Timescale:** 19/02/2016
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As a result of the overall inspection findings, the inspectors recommended that a further review was required by the provider of the quality and safety of care delivered to residents in the designated centre in consultation with staff, residents and their families.

4. Action Required:
Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

Please state the actions you have taken or are planning to take:
• A review of the Quality & Safety of Care delivered to the residents in St Peters will be conducted to inform practice, build on learning and in consultation with staff, residents and their families

Proposed Timescale: 30/03/2016

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A copy of the quality review is to be made available to residents and to the Chief Inspector on completion.

5. Action Required:
Under Regulation 23(f) you are required to: Make available a copy of the review referred to in regulation 23(d) to residents and, if requested, to the chief inspector.

Please state the actions you have taken or are planning to take:
• A copy of the review will be made available to residents and the Chief Inspector once completed

Proposed Timescale: 30/04/2016

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:
Operational procedures described and written policies set out in schedule 5 that included the prevention, detection and response to abuse, management of behaviours
that challenged, risk management and the handling and investigation of complaints, had not been sufficiently and or consistently implemented in practice.

6. **Action Required:**
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

**Please state the actions you have taken or are planning to take:**
- Any allegations of abuse will be reported to the authority in the future as per our policy.
- All Schedule 5 policies are reviewed with staff and an acknowledgement of understanding and awareness will be sought from staff – through educational awareness training

**Proposed Timescale:** 30/04/2016

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The policy in relation to the creation, access to, retention of and destruction of records required review. While records were held and kept in the designated centre, the key to access all records was not available in the centre at all times or available to all staff.

7. **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:**
- The administrator held the key for the files and records – this is now rectified and the key is kept in the nursing home and is available for the inspectors at any given time

**Proposed Timescale:** Immediate

**Proposed Timescale:** 19/02/2016

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
All records set out in Schedules 2, 3 and 4 were not maintained and or available for inspection.
A record with details of any plan relating to a resident in respect of specialist health care following assessment and or case reviews was not maintained in the centre to demonstrate involvement, recommendations and or prescription of care plan.

A record of all incidents in which a resident suffers abuse or harm was not maintained.

Records were not sufficiently completed to include the nature, date and time of incidents, whether medical treatment was required, considered or offered, the names of the persons who were respectively in charge of the designated centre and supervising the resident, and the names and contact details of any witnesses, the results of any investigation and the actions taken.

A record of all medication errors had not been recorded and or reported.

The record of all complaints made by residents or representatives or relatives of residents or by persons working at the designated centre, and the action taken by the registered provider in respect of any such complaint was not consistently maintained.

8. **Action Required:**
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

**Please state the actions you have taken or are planning to take:**
- This resident had been reviewed by the HSE Mental Health Team in November 2015 as well as the Senior Clinical Psychologist. The Mental Health team insist it is not their practice to conduct reports for the residents care plan or the nursing home but instead compile a report for the resident’s GP should there be a necessity. Thus no care plan was devised by them only a verbal report. This is an issue faced by the nursing home for all resident reviews conducted by an external group.
- The clinical psychologist provided a report of the care review and identified a plan of care, however this was not reflected in the residents care plan. The resident behavioural support plan is now in place **Immediate**
- Incident forms are being reviewed to capture all relevant/ comprehensive information that will enable the PIC to conduct a full investigation **March 2016**
- A record of all incidents in accordance with policy is maintained by PIC
- All medication variances are recorded / reported as per policy.
- We do maintain a robust complaints log and actions taken however the anonymous letter had not been recorded as a complaint even though it was thoroughly investigated in November 2015.
- Going forward anonymous letters will be recorded in the complaints log. **Immediate**

Proposed Timescale: Itemised above

**Proposed Timescale:** 31/03/2016
**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:**
All staff had not attended training in relation to behaviour that challenges and some staff did not have sufficient up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that was challenging.

**9. 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:**
- The vast majority of staff had received training in  
  - Behaviours that challenge  
  - Positive behaviour support  
  - One staff member was a new member of staff  
  Taking into account that it was reported that a small minority of staff did not have up to date knowledge, skills to manage behaviours that challenge the following additional training will be provided to enhance learning. This additional specific training will be provided to all staff by the Group Senior Clinical Psychologist  
  - Behaviours that challenge
    - Managing behaviours that challenge  
    - De-escalation and intervention techniques  
    - Reporting / recording / understanding the process involved in documentation
  - Dementia training
    - Vulnerable adults  
    - Understanding dementia  
    - Safeguarding & protecting vulnerable adults
  - Staff training will be followed up with an opportunity for discussion & feedback
  - Acknowledgement of staff understanding of training will be sought through verbal and written feedback and actioned upon if necessary

**Proposed Timescale:** 30/06/2016

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
All reasonable measures to protect residents from all forms of abuse were not sufficiently maintained or demonstrated.

Episodes of challenging, threatening and abusive behaviour that posed a risk to residents and staff had not been sufficiently assessed, reported, recorded, responded to
or managed appropriately.

10. **Action Required:**
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

**Please state the actions you have taken or are planning to take:**
- The safety of the residents is of paramount importance to the team in St Peters – and the PIC responded to the allegations regarding the behaviour of one resident towards others and used her clinical judgement. However the response was not strictly in line with our policy as it was not reported and as a result had not been managed sufficiently in accordance with the policy.
- The PIC will be provided with renewed training in Managing Disclosures.

Proposed Timescale: May 2016

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**Proposed Timescale:** 31/05/2016

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Gaps were found in relation to the implementation of safeguarding procedures and responsibilities, staff awareness, reporting arrangements, supervision and staff training that related to safeguarding vulnerable adults.

All staff were not sufficiently trained and or knowledgeable in relation to the detection and prevention of and responses to abuse to ensure appropriate safeguarding measures were implemented.

11. **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:**
- All staff have been trained in the detection, prevention of and response to abuse. The training provided is in line with the HSE policy and consists of a two – three hour programme that entails an interactive presentation as well as a didactic session on Elder Abuse and is facilitated by a trained instructor. There is records of the training provided and feedback forms from the staff available.
- Staff will be given a refresher training to establish understanding of the policy and its process and in particular resident to resident physical abuse.
- Elder abuse policy will be reviewed and disseminated to all staff.

Proposed Timescale: 31/05/2016
Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All concerns, incidents or allegations of abuse had not been investigated and or reported in accordance with the policy and procedures described by management.

12. Action Required:
Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.

Please state the actions you have taken or are planning to take:
• The PIC and nurse on duty used their clinical judgement in response to the allegation of resident to resident abuse – however the PIC failed inform her Line Managers and HIQA as per policy.
• All concerns, incidents or allegations of abuse will be investigated by the PIC in accordance with policy
• Re-training in managing disclosure will be provided to the PIC May 2016
• Audits on the management of these concerns / incidents or allegations of abuse will be conducted by the Operation’s Manager in liaison with the PIC on a monthly basis – an analysis will be conducted and all actions will be completed in accordance with policy/. Immediate

Proposed Timescale: itemised above

Proposed Timescale: 31/05/2016

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:
Risk management polices and systems that included the identification, assessment and management of actual and potential risks had not been sufficiently implemented in practice to mitigate risks and or ensure adequate controls were in place.

13. Action Required:
Under Regulation 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

Please state the actions you have taken or are planning to take:
• Risk Management policy reviewed & disseminated to all staff – April 2016
### Proposed Timescale: 30/04/2016

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Hazard identification, assessment and management of risks had not been sufficiently implemented in practice to mitigate risks and or ensure adequate controls were in place.

Allegations and episodes of abusive and aggressive behaviour had not been sufficiently reported and assessed with adequate measures put in place.

#### 14. 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:
- Review of risk assessments to measure potential risk of abuse and identify controls that should be actioned on to reduce risks of abuse  
  April 2016

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### Proposed Timescale: 30/04/2016

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Deficiencies were found in relation to the management of risks to inform learning following all adverse incidents involving residents.

#### 15. 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:
- We have a risk register in place but we will ensure it captures all risks  
  immediate
- Conduct an audit of risk register on a three monthly basis to analyse the findings  
  April 2016

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### Proposed Timescale: 30/04/2016

**Theme:**
Safe care and support
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Infection control procedures had not been adequately or consistently maintained to ensure high standards in practice.

16. Action Required:
Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

Please state the actions you have taken or are planning to take:
- Training in Infection Prevention & Control (HIQA & HSE guidelines) provided to staff Bi Annually: 2/3/16, 5/4/16, 14/6/16, 19/7/16, 11/10/16, 16/11/16
- Review of housekeeping schedules conducted to ensure compliance Immediate
- Health & Safety meetings conducted on a monthly basis

Proposed Timescale: Itemised above

Proposed Timescale: 16/11/2016

Outcome 10: Notification of Incidents
Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Allegations, suspicions and reported abuse had not been notified to the authority or chief inspector, as required.

Allegations of staff misconduct had not been notified to the authority or chief inspector, as required.

17. Action Required:
Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

Please state the actions you have taken or are planning to take:
- All allegations or suspicions of abuse made whether founded or unfounded will be notified to the Chief Inspector as previously noted. as required

Proposed Timescale: Immediate

Proposed Timescale: 19/02/2016
### 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:**
From a review of resident clinical records, inspectors found gaps in communications and incomplete records in parts.

A comprehensive assessment to include the behavioural support needs of a resident had not been sufficiently maintained and communicated to all staff.

#### 18. Action Required:
Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

Please state the actions you have taken or are planning to take:
- While a behavioural support plan was discussed between the Clinical Psychologist and the PIC and a discussion and plan was given to the staff this was not reflected in the resident's care plan
- A comprehensive care plan on behavioural support is now in place in the residents care plan 
- Guidelines for staff in supporting the resident will be developed by the psychologist March 2016
- Guidelines will be communicated to all staff who take care of the resident April 2016

**Proposed Timescale:** 30/04/2016

### 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 sufficiently informed by a comprehensive assessment that was reviewed and updated at suitable intervals to reflect changes and or events.

#### 19. 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:
- All care plans are reviewed on a four monthly basis
• The care plan for this resident is updated and reflective of the current needs of the resident. Immediate

**Proposed Timescale:** 19/02/2016

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Gaps found in the clinical records and incident management or reporting did not demonstrate a high standard of evidence based nursing care in accordance with professional guidelines.

**20. 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 Cnáimhseachais.

**Please state the actions you have taken or are planning to take:**
- Records will be completed to reflect all aspects of care provided to the resident by
  - Allied health care professionals (where compliant)
  - Nursing records to reflect all aspects of care including any incidents // concerns / accidents / allegations and to include a full investigation and outcome - Immediate

**Proposed Timescale:** 19/02/2016

**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:**
All complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint were not fully and properly maintained or recorded, and distinct from a resident’s individual care records.

**21. 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:**
- All concerns / complaints will be fully investigated in accordance with our policy by the
PIC
• A log of all complaints will be maintained as before irrespective of them being verbal, written, anonymous, founded or unfounded. Immediate

Proposed Timescale: 19/02/2016

**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A review of staff numbers, skills mix and supervision arrangements were required.

A change and high turnover of staff had negatively impacted on the skill mix of staff and the team dynamic.

Staffing arrangements did not consistently ensure that the number and skill mix of staff was suitable and or sufficiently experienced and knowledgeable of the assessed needs and requirements of all residents.

An increased number of adverse events and serious incidents involving residents had occurred in the centre within previous months and a significant number of incidents had not been reported appropriately within the organisational structure.

**22. 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:**
• Staffing levels have not changed as agreed per statement of purpose and within recommended levels. In 2015 staff hours were increased by 20 hours per week.
• Some staff members will always say there are not enough staff if asked.
• In 2015 there was a total of 730 (12 hour) nurse registered shifts, we only used agency for 24.5 shifts or 3% of the total. We never used agency for carers as there are sufficient numbers.
• Call bell response audits (including bed and chair sensor alarms for Resident’s unable to use or understand call bells) are conducted by the PIC to evaluate staffing resources as well to monitor effective delivery of care
• Allocation of staff member specifically for supervision was introduced to ensure continuous supervision is on the floor
• Skills mix is determined by the PIC while compiling rosters and is determined by the needs of the residents
• A review of the dependency levels will be conducted to ascertain that safe staffing levels are in place
**Proposed Timescale:** 29/02/2016

**Theme:** Workforce

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

All staff had not had access to appropriate training relevant to meet all residents’ needs.

All staff were not adequately trained in positive behaviour support and or managing behaviour that was challenging including de-escalation and intervention techniques.

23. **Action Required:**

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:
- Training was provided for 38 staff out of a compliment of 40 in
  - Behaviours that challenge
  - Positive behaviour support

Taking into account that it was reported that staff did not have up to date knowledge, skills to manage behaviours that challenge the following additional training will be provided to enhance learning. This additional specific training will be provided to all staff by the clinical psychologist
- Behaviours that challenge JUNE 2016
  - Managing behaviours that challenge
  - De-escalation and intervention techniques
  - Reporting / recording / understanding the process involved in documentation
- Dementia training JUNE 2016
  - Vulnerable adults
  - Understanding dementia
  - Safeguarding & protecting vulnerable adults
- Staff training will be followed up with an opportunity for discussion & feedback
- Acknowledgement of staff understanding of training will be sought through verbal and written feedback and actioned upon if necessary

**Proposed Timescale:** 30/06/2016

**Theme:** Workforce

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

Gaps were identified in staff training and supervision arrangements.
The management systems and arrangements in place had not ensured all persons working in the centre were appropriately supervised, supported or developed to ensure the assessed needs of residents were maintained.

24. **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:**
- Annual appraisals are conducted for all staff
- Clinical supervision conducted for new staff in first year (twice a year)
- CNM / staff nurses / Senior HCA provide daily supervision
- Daily handovers conducted to inform / support staff
- Staff meetings held regularly for sharing of information

Proposed Timescale: February 2016 and ongoing

**Proposed Timescale:** 29/02/2016