

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St. Peter's Nursing Home
Centre ID:	OSV-0000122
Centre address:	Sea Road, Castlebellingham, Louth.
Telephone number:	042 938 2106
Email address:	stpeters@trinitycare.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Costern
Provider Nominee:	Keith Robinson
Lead inspector:	Sonia McCague
Support inspector(s):	Catherine Connolly Gargan
Type of inspection	Announced
Number of residents on the date of inspection:	36
Number of vacancies on the date of inspection:	3

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 inform a registration renewal decision. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 30 August 2016 09:20 To: 30 August 2016 20:00

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

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

Summary of findings from this inspection

This was an announced inspection which took place over one day following a completed application to renew the registration of the centre.

As part of the inspection process, the inspectors met with the provider nominee, the person in charge, operations manager, residents, visitors and staff members. Inspectors observed practices and reviewed documentation such as care plans,

general and clinical records, incident records, policies and procedures, fire safety and risk management documentation and staff records.

All information, including notifications received by the Health Information and Quality Authority (HIQA) since the last inspection was followed up.

The action plan response to the previous inspection 17 May 2016 was also followed up and found to have been addressed. The inspectors' findings are outlined in the body of the report.

Overall, inspectors found good governance and management systems in place, with adequate arrangements available to meet the health and social care needs of residents.

Residents engaged readily with inspectors and the verbal and written feedback from residents, relatives and staff was positive in relation to the care, services and arrangements provided.

The inspectors found evidence of good practice in a range of areas. The premises, facilities, furnishings and décor were of a good standard and many rooms had been refurbished since the last inspection. Staff interacted well with residents and in a respectful, responsive and appropriate manner. Staff demonstrated sufficient knowledge of residents' needs, likes, dislikes and preferences.

While compliance was awarded to most of the 18 outcomes inspected, some improvements were required to comply with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. In the staff files reviewed, one staff member did have a declaration of Garda Síochána vetting and clearance. The provider nominee and human resource director were subsequently advised that any staff without a declaration of Garda Síochána vetting and clearance should not be working in the centre. Assurances were given by the provider nominee verbally and via email to make alternative arrangements for staff rostered for work without Garda Síochána vetting and to comply with legislation.

The findings and required improvements in relation to completion of Garda Síochána vetting prior to staff being employed to work in the centre, contracts of care, recording practices including care planning, staff training, review and appraisal which are discussed within the body of this report and set out in the action plan at the end for response.

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):

No actions were required from the previous inspection.

Findings:

There was a written statement of purpose that described the service and facilities that are provided in the centre. The statement of purpose consisted of a statement of the aims, objectives and ethos of the designated centre.

It was available in the centre and contained the information required by Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended).

Staff were familiar with the statement of purpose and function, and reviews and changes in relation to the designated centre were updated and communicated to the Authority accordingly.

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):

No actions were required from the previous inspection.

Findings:

The quality of care and experience of the residents was monitored and developed on an ongoing basis. Effective management systems and sufficient resources were in place to ensure the delivery of safe, quality care services. However, the appraisal of staff by the person in charge required improvement as outlined in the action plan of outcome 18.

There was a clearly defined management structure that identified the lines of authority and accountability. The person in charge was supported by an operational manager and by the person nominated on behalf of the provider who attended the centre on a fortnightly basis. Both had involvement in the audits and quality review of care on each visit to the centre.

Other resources that supported the person in charge included the director of human resources in relation to staffing, recruitment and training or development, a maintenance person and the facilities manager who audited the premises six monthly and a catering manager.

The person in charge as director of nursing worked full time in a supernumerary capacity Monday to Friday each week. The clinical nurse manager worked 16 hours weekly in a supernumerary capacity including weekends. On-call arrangements were in place.

An annual review of the quality and safety of care delivered to residents to inform areas for improvement in 2016 was completed and reviewed at the previous inspection.

There was evidence of consultation with residents and their representatives.

Judgment:

Compliant

Outcome 03: Information for residents

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There was an information booklet as the guide to the centre and services available to residents.

A written contract was available which included details of the services to be provided for residents' including those in receipt of financial support under the Nursing Homes

Support Scheme. Any other service of which the resident may choose to avail but which is not included in the Nursing Homes Support Scheme or to which the resident may not be entitled to under any other arrangement or entitlement was also outlined.

However, in the sample of contracts inspected, inspectors found that the agreements were incomplete in parts as the overall fees to be charged and or the signature by the resident or representative and or the person nominated on behalf of the provider was not completed, as required.

Judgment:
Substantially 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:
The designated centre was managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

There was a clearly defined management structure which identified the lines of authority and accountability in the centre. The person in charge worked on a full time basis and had a clinical nurse manager or nurse to assume responsibility of the designated centre in her absence.

The person in charge demonstrated sufficient knowledge and implementation of the legislation requirements and was aware of her statutory responsibilities. Inspectors were satisfied that the person in charge was engaged in the governance, operational management and administration of the centre on a regular and consistent basis and had demonstrated that she was committed to improving outcomes for the resident group.

Residents and relatives were familiar with the person in charge and were complimentary of her and the staff team.

Judgment:
Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and

ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Governance, Leadership and Management

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

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

Findings:

Records listed in schedule 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) were available, easily retrievable and maintained securely.

The requirements from the previous inspection 17 May 2016 were found to have been addressed that included:

- ensuring the actual name of the person informed following an incident and the date and time they were notified at was included in incident records
- the completed assessment to identify each or any resident's relatives, family or significant other/s to be involved (or not) with the resident's consent following admission.

Records including the statement of purpose, residents guide, previous inspection reports, and directory of residents, emergency procedures, and clinical documents along with records related to all residents and staff were available for inspection.

A record of visitors and the directory of residents was recorded and maintained in the centre.

The designated centre had written operational policies referenced in Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). Schedule 5 policies and procedures were made available and the inspectors reviewed a number of policies which included health and safety, responding to emergencies and risk management policies and procedures, management of complaints, the prevention, detection and response to abuse, medication management and end of life care and found that they guided and demonstrated practice within this centre.

A review of staff files found systems in place for recruitment, selection and induction of staff. However, the files reviewed were incomplete in accordance with schedule 2. Garda Síochána vetting for one staff member was outstanding. This is discussed further in outcome 7 and presented as a requirement in the action plan.

In addition, a performance review and appraisal of staff had not been implemented or demonstrated in the staff file reviewed. The person in charge acknowledged this and was to take appropriate action following feedback. This is discussed further in outcome

18 and presented as a requirement in outcome 18 action plan.

General and clinical records were found to be reasonably maintained and updated. The transition from hard copy records to the computerised soft copy system had been introduced since the last inspection. Residents could access their records on request and were satisfied with the arrangements in place.

A system was in place to records residents' property on admission when completing the admission process and the contract of care. These records required improvement to ensure a sufficient detail of items was recorded and dual signed.

Monetary transactions undertaken between and on behalf of residents by staff were examined and balances were found to be accurate. However, improvement was required in relation to the detailing of information to support each transaction.

A copy of a current and written declaration of insurance cover was available in accordance with regulatory requirements and on display in the entrance hall.

Judgment:
Substantially Compliant

Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Governance, Leadership and Management

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

Findings:
The provider and person in charge were aware of their responsibility to notify the Chief inspector of a proposed or unplanned absence of the Person in Charge.

There were arrangements in place for the management of the designated centre in the absence of the Person in Charge; however, an absence for more than 28 days was not expected.

Judgment:
Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a

positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Measures to protect residents being harmed or suffering abuse were in place. There were written operational policies relating to safeguarding, prevention, detection and responding to abuse, management of behaviours that challenge and the use of restraint.

The policy on, and procedures for the prevention, detection and response to abuse reflected the national policy on safeguarding vulnerable adults, which was available to support the centre's policy.

Staff had received training in adult protection and safeguarding residents to protect them from harm and abuse.

Staff knew what constituted abuse and knew what to do in the event of an allegation, suspicion or disclosure of abuse, including who to report any incidents to. There were no active incidents, allegations, or suspicions of abuse under investigation.

Systems were in place that included management and multi-disciplinary team (MDT) meetings to discuss incidents and mitigate risks of harm to residents. The person in charge and support team assumed responsibility to monitor the systems in place to protect residents. The staff team were confident that there were no barriers to them or residents disclosing abuse or concerns.

However inspectors found that a staff member whose Garda Síochána vetting application was not fully processed was rostered to work on night duty. The provider nominee and human resource director were advised that any staff without a declaration of Garda Síochána vetting should not be working in the centre. Assurances were given verbally and via email to comply with this directive and alternative staffing arrangements were put in place to ensure that all staff rostered to work in the centre had Garda Síochána vetting and clearance.

Residents who communicated to and with the inspector said they felt safe and able to report any concerns. Relatives who participated in the inspection process also shared this view.

Efforts were made to identify and alleviate the underlying causes of some residents' behaviour that was challenging and training programs were provided and were ongoing to inform and support staff practice.

Some residents had responsive behaviours or behaviours that challenge, also known as behavioural and psychological signs of dementia (BPSD). Staff who spoke with

inspectors were familiar with appropriate interventions to use and described training provided. During the inspection staff approached residents with BPSD in a sensitive and appropriate manner and the residents responded positively to the techniques used by staff. Further training specific to dementia was scheduled in October 2016.

There was evidence of interdisciplinary collaboration and person centred approaches with positive outcomes for residents who had responsive behaviours. Incidents were reviewed systematically and regularly by the management and MDT. A review and audit by management of all incidents including behaviour that was challenging was recorded which showed that appropriate action was taken to address identified risks and bring about improvements.

Inspectors read a number of incident records involving a resident that had displayed behaviours that challenged which impacted negatively on other residents. On enquiry, staff and a member of the multi-disciplinary team visiting the centre told inspectors that the trigger for the behaviour had been identified prompting a review of medicine with the general practitioner that had been prescribed following return from hospital. The episodes of behaviour that challenged had significantly reduced as a result of changes made to the prescribed medicines.

There were no reported incidents of behaviours that challenged in the past month. While inspectors were informed by staff of the behaviour support interventions used to de-escalate and respond to episodes of behaviour that challenged, the behaviour support plan (BSP) available was not sufficiently detailed. The inspectors found that the BSP did not describe or include both proactive strategies to reduce behaviours that are difficult or potentially dangerous and effective reactive strategies to be used to manage crises without compromising the safety or the dignity of all concerned. This required improvement is outlined in the action plan for outcome 11.

There were systems in place to safeguard residents' money and personal property. An improvement in the recording of each transaction is outlined in outcome 5.

Where restraint was used attempts were made to ensure practice and measures in use were in line with the national policy on restraint. Chemical restraint was not in use and a low level (14%) of bedrail use was reported and seen. Inspectors reviewed the use of restraint and found that 5 residents used bedrails. Inspectors noted that the appropriate risk assessments had been undertaken. Staff spoken with and the restraint register confirmed the various alternatives that had been tried or offered prior to the use of bedrails. Additional equipment such as low beds and sensor alarms was in use to reduce the need for bedrails. There was evidence that alternative measures had been used or offered prior to measures in use at the time of the inspection.

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):

No actions were required from the previous inspection.

Findings:

The health and safety of residents, visitors and staff was promoted in this centre.

The centre had policies and procedures relating to health and safety. A current health and safety statement was available and in place. Risk management procedures were in place supported by a policy that included items such as self harm and missing person set out in regulation 26(1). A risk register which focused primarily on clinical risks associated with residents was maintained. Further development of the risk register was required and acknowledged by the person in charge and operations manager to ensure all risk such as operational and environmental was identified, assessed and escalated appropriately to the responsible person with suitable controls put in place, as required by the risk management policy.

There was an emergency plan in place for responding to major incidents likely to cause injury or serious disruption to essential services or damage to property.

Satisfactory practices and procedures were found in relation to the prevention and control of healthcare associated infections.

Arrangements were in place for investigating and learning from serious incidents and adverse events involving residents. Audits of staffing levels and absences, resident dependency, admissions and discharge or death, falls, wounds, pressure ulcers, complaints and restraint use were maintained which demonstrated a strategic approach to meeting resident needs, and to mitigate identified risk and an overall reduction of likely incidents and event.

Reasonable measures were in place to prevent accidents in the centre and within the grounds. Staff were trained in moving and handling of residents and appropriate techniques were observed. Training in infection control and fire safety was also confirmed by staff and evident in the training records. The training records also showed that all staff with the exception of two had completed fire safety training. Staff interviewed and records reviewed confirmed an induction to fire safety and fire drills had been completed by staff members.

A fire safety register and associated records were maintained and precautions against the risk of fire were in place. Service records confirmed that the fire alarm system and fire safety equipment including emergency lighting and extinguishers were serviced appropriately and serviced on a regular basis. Evacuation plans and procedures were displayed throughout the centre and emergency exits were clearly identified. Means of escape and fire exits were unobstructed in all areas with the exception to the corridor where the laundry department was located. Inspectors saw a number of linen skips stored along a corridor on the afternoon of the inspection. This practice may hamper an efficient evacuation in the event of an emergency in this part of the centre where

residents' bedrooms were also located. A review of storage arrangements and facilities was required.

Staff training records showed that all staff had not completed up to date training in cardio pulmonary resuscitation (CPR) to ensure an appropriate response to emergency events and advanced care directives. Inspectors were informed that a date for CPR training was scheduled in October 2016 to include recently employed staff and as a refresher course to existing staff. Training requirements outstanding are outlined in the action plan of outcome 18.

Judgment:

Substantially Compliant

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):

No actions were required from the previous inspection.

Findings:

There were written operational policies relating to Medication management in relation to practices and procedures associated with the ordering, prescribing, and administration of medicines to residents. The practices relating to the prescribing, administration and storage of medication were found to be satisfactory.

All medicines were stored in secure cabinets and a register of controlled medicines was maintained with the stock balances checked and signed for by two nurses each day.

Residents had access to a pharmacist and general practitioner (GP) of their choice and the majority opted for the services of the GP attending the centre.

Written evidence was available that three-monthly reviews of medicines were carried out. Support and advice were available for the supplying pharmacy.

Inspectors noted that there had been some medication errors earlier in the year which had been investigated and any actions required were completed.

Judgment:

Compliant

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
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: A record of incidents occurring in the designated centre was maintained and, where required, notified to the Chief Inspector.</p> <p>The inspectors found that incidents occurring in the centre had been recorded and management systems were in place to alert staff to notify the Authority of notifiable incidents within three days.</p> <p>Quarterly reports were provided, where relevant, that included requirements such as the number of deaths and use of physical and chemical restraint. The application and or use of environmental restrictions such as coded door locks in parts of the centre were to be included in the centre's policy and reported going forward if in use.</p> <p>Where no report was required under paragraphs 31(1) or 31(3), a report to the Chief Inspector at the end of the six month period for 2016 was submitted since the inspection, as prescribed in the regulations.</p>
<p>Judgment: Compliant</p>

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

<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: Inspectors were satisfied that each resident's wellbeing and welfare was maintained by a high standard of nursing care and appropriate medical and allied health care. The transition from hard copy clinical records to a soft or computerised record had been completed since the previous inspection and improvements required were identified.</p> <p>Residents were satisfied with the health and social care service provided. Residents had</p>

access to GP services and out-of-hours medical cover was provided. Psychiatry and psychology services were available and provided very valuable services to the residents. A full range of other services was available on referral including speech and language therapy (SALT) and dietic services. Physiotherapy and occupational therapy (OT) services were available via the provider on a fortnightly basis on site. Chiropody, dental and optical services were also provided on referral. Inspectors reviewed residents' records and found that some residents had been referred to and had received the services of these specialists.

There were processes in place to ensure that when residents were admitted, transferred or discharged to and from the centre, relevant and appropriate information about their care and treatment was maintained and shared between providers and services.

Inspectors reviewed a selection of care plans. There was evidence of a pre-assessment undertaken prior to admission for residents. There was a documented assessment of all activities of daily living, including communication, personal hygiene, continence, eating and drinking, mobility, spirituality and sleep. There was evidence of a range of assessment tools being used to monitor areas such as the risk of falls, use of bedrails, malnutrition and pressure ulcer development.

Clinical observations such as blood pressure, pulse and weight were assessed on admission and as required thereafter.

Arrangements were in place so that each resident's care plan was kept under formal review as required by the resident's changing needs or circumstances and was reviewed no less frequently than at four-monthly intervals. The development and review of care plans was done in consultation with residents or their representatives. In the sample of care plans reviewed the inspectors found evidence that interventions in use and described by staff were not sufficiently detailed in the related care plan. As referenced in other outcomes, improvement was required to ensure the identified need or problem and care goal was clear with sufficient information and details that described the interventions to direct care and achieve the planned goal.

Inspectors reviewed the management of clinical issues such as falls management and found they were well managed and guided by robust policies and practices. Risk assessments had been undertaken to prevent and reduce the risk of falls. Each fall was analysed to identify any possible causes, patterns or trends. The management team reviewed each fall and other incidents in their fortnightly meetings and audits were maintained to ensure compliance with the policy. Residents' rights to refuse treatments were respected. For example, a resident identified at risk of falling refused to wear hip savers or use an alternative aid recommended by allied healthcare professionals.

Residents identified at risk of developing pressure ulcers had specific equipment in place to mitigate the risk, such as repositioning regimes, pressure relieving mattresses and cushions. There were two residents with pressure ulcers at the time of inspection. Six residents had a wound or skin tear. Inspectors reviewed the management of wound care and found that improvement was required in line with the centre's policy and best practice. Some wound care plans and records were not updated to reflect the status of the wound following each dressing and the interventions used in practice were not consistently outlined in the related care plan.

Residents had opportunities to participate in activities that were meaningful and purposeful to them, and which suited their needs, interests and capacities. An activity staff member was on duty for five days each week. She organised a variety of activities which were posted weekly in reception area and daily in a day room. The activity schedule included activities arranged for the mornings and afternoons and included exercise classes, ball or balloon games, music, flower arranging, films, quizzes, reading aloud short stories, art and religious activities. One to one activities such as hand massage were also included for residents that did not choose the group activity. The member of staff dedicated to the provision and co-ordination of activity was available during the inspection and described recent outings and trips that residents were supported on. Photographs were on display to confirm the outings. This staff member along with care staff interacted well with residents while facilitating engagement in meaningful activities observed within the centre. Many residents were complimentary of and satisfied with activities and support provided by staff to engage in social activity.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

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

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

The location, design and layout of the centre was suitable for its stated purpose and met residents' individual and collective needs in a comfortable and homely manner. The premises was in line with Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Some recommendations for improvement were identified and to be considered and addressed within the plan to commence an extension to the centre later this year.

The centre was clean, warm and well ventilated in areas used by residents. The entrance was staffed daily (Monday to Friday) by an administration personnel member. Entry and exit to the centre was controlled at the main entrance.

It is a single storey purpose built centre which has been operational prior to 2009. The building design and layout was of a good standard that could comfortably accommodate

39 residents in 33 single occupancy bedrooms and three twin bedrooms with full ensuite facilities. Sitting rooms, lounges and dining rooms were spacious and decorated to a high standard with colourfully co-ordinated furnishings and fittings.

Furniture and equipment seen in use by residents was in good working condition and appropriate to their needs. Supportive equipment such as call bell facilities, remote control beds, chairs and televisions along with battery operated or motorised pressure relieving aids were seen in use by residents that promoted their well being.

Corridors and door entrances were wide and spacious to facilitate modified, support or bulky equipment and aids used and required by residents. Bedrooms were spacious to accommodate personal equipment and devices required. Handrails were provided on corridors and grab rails were available in bathroom and toilet facilities. Additional grab rails had been ordered and were to be put in the ensuite of one resident's room following his request.

External gardens were available to residents and their relatives. Two secure courtyards and internal areas to access outdoors were freely available and used by residents and their visitors during this inspection. A spacious care park adjoined the centre and a car or minibus taxi was available to facilitate residents requiring transport.

Recommendations for improvement identified and relayed to the provider nominee, person in charge and operations manager included:

- Storage arrangements, as outlined in outcome 8
- Dual use of oratory as a visitor's room
- The layout of furniture in twin rooms and close proximity of beds.

Judgment:

Substantially Compliant

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:

Inspectors found that there were policies and procedures in place for the management of complaints.

Inspectors were informed that there were no formal or written complaints received since the last inspection. There was a log and record of informal concerns or verbal complaints received by staff. A register was maintained and was available to inspectors.

The information recorded demonstrated that concerns expressed by residents and or their relatives were recorded and addressed in a timely manner following communication with staff and referral to the person in charge. The outcomes recorded showed that concerns raised had been addressed to the satisfaction of the complainant.

The arrangements in place to make a complaint were displayed in the entrance to the centre, outlined in the residents guide and available in statement of purpose. There was a nominated complaints officer and an appeals procedure formed part of the process.

Residents and relatives who completed questionnaires and who spoken with inspectors during the inspection were aware of how to make a complaint and were satisfied with arrangements in place and felt supported in raising issues.

A system to monitor complaints was in place which provided an opportunity for learning and improvement.

Judgment:
Compliant

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:
Person-centred care and support

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

Findings:
Inspectors were satisfied that caring for a resident at end of life was regarded as an important part of the care service provided. There were care practices and arrangements in place so that residents received end-of-life care in a way that met their individual needs and wishes. The practices were supported by an end-of-life policy.

Having reviewed a sample of care plans inspectors were satisfied that each resident or their relative had been given the opportunity to outline their wishes regarding end of life.

Staff spoken with confirmed that the palliative care team provide advice and support as needed. Resident's religious and cultural practices were facilitated. Family and friends were facilitated to be with the resident at the end of life. Inspectors spoke with the relative of a resident who died in the centre who was complimentary about the care and services provided by the staff team.

Suitable equipment, symbols and an oratory facility with necessary religious artefacts were available to improve the level of respect shown to the deceased.

Judgment:
Compliant

Outcome 15: Food and Nutrition

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors were satisfied that each resident was provided with food and drinks at times and in quantities adequate for their needs. Food was properly prepared, cooked and served, and was wholesome and nutritious. Assistance was offered to residents in a discreet and sensitive manner.

Validated nutrition assessment tools were used to identify residents at potential risk of malnutrition or dehydration on admission and were regularly reviewed thereafter. Weights were also recorded on a monthly basis or more frequently if required.

Records showed that some residents had been referred for a dietetic review. Medicine prescription records showed that supplements were prescribed by a doctor and administered accordingly. Again improvement was required to ensure the nutritional needs and recommended guidance provided by specialists such as speech and language therapists is reflected and updated in the related care plan. Inspectors saw that records of residents' food intake and fluid balance were completed when required. However, the care plan did not specify the daily fluid intake target to be achieved and as described by staff. This required improvement is outlined in the action plan for outcome 11.

Inspectors saw that residents had been reviewed by a speech and language therapist when required. Inspectors saw that the care plans for these residents required updating to reflect the recommendations made. This is included in the action plan of outcome 11. Inspectors observed practices and saw that staff were using appropriate techniques when assisting these residents with their meals. It was noted that meals were an unhurried social experience. While the supervision level by staff in one of the two dining rooms at lunch time was appropriate it was not as supportive in the other dining room. The person in charge agreed to review the supervision of residents and support arrangements from staff during meal times. This required improvement is outlined in the action plan for outcome 18.

Residents had a choice of where to have their meals. The tables in the dining rooms were attractively and invitingly set and a menu for the day was displayed.

The food provided was appropriately presented and provided in sufficient quantities. Inspectors noted that residents who required their meal in altered consistencies had the same choices as other residents. In addition these were served attractively.

A 24 hour menu was also available, to compliment the daily menu, offering a selection of snacks. Inspectors saw that snacks and fluids were readily available. Facilities to make hot drinks and store snacks in a fridge was available in one dining area. Staff said that the fridge would be stocked with sandwiches, snacks, meat and or cheeses should they be required.

Inspectors visited the kitchen, spoke to the catering manager and chef on duty and viewed the food on offer. It was observed that food was wholesome, nutritious while also properly prepared, stored and cooked. Residents spoken with also expressed satisfaction with the food provided. The chef met and spoke with residents in the dining room that adjoined the kitchen to ascertain their views and seek feedback on the meal and food provided. The quality of food was a recurrent topic listed on the agenda and discussed by residents during their monthly meeting.

Judgment:
Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

Findings:
There was evidence that residents were consulted with and had opportunities to participate in the organisation of the centre in that a resident's forum was facilitated and the group met on a regular basis. Information sessions and meetings had been held for residents' family members and their involvement was central to many residents.

Access to and information in relation to independent advocacy services was available to residents and on display in the reception area. Residents' independence and autonomy was promoted. For example, inspectors saw residents being able to access internal and external parts of the centre independently and on request if in need of support at the time of their choosing with their mobility aids. In the main, residents were able to make

choices about how they lived their lives in a way that reflected their individual preferences for example, participate in activities, read, watch television or meet with visitors in private and in the company of others.

The inspectors saw that residents' privacy and dignity was respected and personal care was provided in their own en-suite and bedrooms and they could receive visitors in private. The oratory was also allocated as the visitor room. While the oratory/visitor's room was available for use during the inspection, inspectors recommended that this dual purpose be reviewed in light of having three twin bedrooms and residents from religious orders.

Residents were of the varied age range, they were seen to be well dressed in appropriate manner with clothes and personal effects of their choosing.

Respondents who completed questionnaires and spoke with inspectors confirmed that staff informed them of their relatives' health care needs and any changes in the conditions.

Judgment:

Compliant

Outcome 17: Residents' clothing and personal property and possessions Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The inspectors saw that there was adequate space provided for residents' personal possessions and mobility aids. Residents had a locked facility in their bedrooms.

There were arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Judgment:

Compliant

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:

Inspectors reviewed actual and planned rosters for staff, and found that staffing levels and skill mix were sufficient to meet the needs of the residents. Inspectors were informed that a number of staff had been recruited to address the turnover of staff (13) and ensure that the centre was sufficiently staffed at all times. Contingency plans were described as in place to response to planned leave and or unplanned absences. The provider nominee and operations manager told inspectors of an ongoing recruitment process and the person in charge told inspectors that agency nursing and care staff had not been required in the centre since her appointment in March 2016.

Staff confirmed that they had sufficient time to carry out their duties and responsibilities and explained the systems in place to supervise staff on the daily basis. In addition to the person in charge, a minimum of two nurses was rostered daily and one nurse at night. In discussions with staff, they confirmed that they were supported to carry out their work by the person in charge and the clinical nurse manager.

Staff were seen to be supportive of residents and responsive to their needs. Seven residents had completed a questionnaire regarding the centre. In these questionnaires, all residents were complimentary of the staff team and person in charge. One resident said 'staff are like my family', while others said they 'were always available' and 'answer the call bell quickly'. Inspectors spoke with residents' relatives, who were complimentary of the person in charge, the staff group and were satisfied with the standard of care provided to residents. One person who completed a questionnaire prior to the inspection raised issues about the staffing levels between 5:30pm and 7pm. This was communicated to the person in charge for follow up.

Inspectors spoke with staff members, all of whom were knowledgeable of residents' needs and of operational procedures. Daily communications via handover between shifts and allocation of staff to residents was in place. Staff reported good working relationships and improvements in the organisation of services and care. A staff satisfaction survey had been undertaken since the last inspection. The summary of results was provided to inspectors that reported an overall positive response from participants. The entire feedback was yet to be disseminated within a report.

Staff who spoke with inspectors expressed satisfaction with the induction process following their appointment, ongoing training opportunities and support arrangements.

Staff told inspectors they had received mandatory and other training courses relevant to their role. Staff handbooks and information was available to them as and when required.

Training records viewed by the inspectors indicated that all staff were up to date with mandatory training in moving and handling and the prevention, detection and management of abuse. As outlined in outcome 8, two staff did not have a training date in fire safety but had completed an induction to fire safety and participated in a subsequent fire drill and simulated evacuation. Training in infection control and health and safety had also been completed by various levels of staff.

A record was maintained of staff nurses' current registration details with the professional body.

Recruitment procedures were in place and samples of staff files were reviewed. While inspectors found substantial compliance in the sample of staff files examined against the requirements of schedule 2 records, one staff file did not contain a declaration of Garda Síochána vetting and clearance. This was discussed in outcome 7 and presented as a requirement in outcome 7 action plan.

The centre's recruitment procedure included probationary and annual appraisal of staff, however, this was not consistently implemented in practice, as referenced in outcome 2. Records and staff files viewed by inspectors indicated that staff were not subject to frequent reviews following their employment in the centre, as well as annual appraisals thereafter. In addition, a formal process of carrying out exit interviews with staff leaving this employment was recommended by inspectors to inform staff retention and development programmes.

Volunteers were not actively engaged in the centre.

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:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	St. Peter's Nursing Home
Centre ID:	OSV-0000122
Date of inspection:	30/08/2016
Date of response:	13/09/2016

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 03: Information for residents

Theme:

Governance, Leadership and Management

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

In the sample of contracts inspected, inspectors found that the agreements were incomplete in parts as the overall fees to be charged was not completed, as required.

1. Action Required:

Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated

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

centre and includes details of the fees, if any, to be charged for such services.

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

All contracts of Care will be reviewed and all details including fees will be clearly set out on the Contract of Care to identify specific charges to Services.

Proposed Timescale: 16/09/2016

Theme:

Governance, Leadership and Management

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

In the sample of contracts selected, inspectors found that the agreements were incomplete in parts as the signature by the resident or representative and or the person nominated on behalf of the provider was not completed, as required.

2. Action Required:

Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

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

All contracts of Care will be reviewed and PIC will ensure that all areas / parts of the Contract of Care including resident or representative signature and the nominated person on behalf of the provider will be completed and signed

Proposed Timescale: 16/09/2016

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:

Monetary transactions undertaken between and on behalf of residents by staff required improvement in relation to the detailing of information to support each transaction.

Residents property records required improvement to ensure a sufficient detail of items was recorded and dual signed.

3. 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:

Monetary properties of the residents in the Home are securely kept in the safe and the Administrator has a copy of transactions made by the residents which are dual signed. However, this transaction was not in the box that these properties were kept on the day of the inspection but was kept in the administrator's folder. To ensure improvement and sufficient details of records, a copy of this document will now be kept in the safe and the dual signature will continue to be recorded.

Proposed Timescale: 06/09/2016

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

Inspectors found that a staff member whose Garda Síochána vetting application was not fully processed was rostered to work on night duty.

4. 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:

Staff member whose Garda vetting was not fully processed was taken off the roster immediately to ensure compliance. Evidence of Garda vetting application and the self-declaration form are kept on file of the staff member. However, PIC will ensure that the approved Garda Vetting is physically in place prior to rostering staff in the Home.

Proposed Timescale: 13/09/2016

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:

The risk register focused primarily on clinical risks associated with residents and required further development to ensure all risk such as operational and environmental were identified, assessed, controlled and escalated appropriately to the responsible person.

5. Action Required:

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

the designated centre.

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

The Risk Register will be reviewed by PIC and Operations Manager to ensure that risks in all aspects including clinical, operational and environmental will be identified, assessed and appropriate measures put in place including the identification of the responsible person.

Proposed Timescale: 14/10/2016

Theme:

Safe care and support

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

A number of linen skips stored along a corridor on the afternoon of the inspection may hamper an efficient evacuation in the event of an emergency.

A review of storage arrangements and facilities was required.

6. Action Required:

Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

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

A review of Storage arrangements will be completed by the 14th October 2016 and an implementation plan will be put in place that will address this issue.

Proposed Timescale: 14/10/2016

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:

Improvement was required to ensure the identified need or problem and care goal was clear with sufficient information and details that described the interventions to direct care and achieve the planned goal.

The management of wound care required improvement in line with the centre's policy and best practice. Some wound care plans and records were not updated to reflect the status of the wound following each dressing and the interventions used in practice were not consistently outlined in the related care plan.

Some care plans were not sufficiently specific to include or specify the daily fluid intake

target to be achieved and described by staff.

The behaviour support care plan was not sufficiently detailed and did not describe or include both proactive strategies described by staff to reduce behaviours that are difficult or potentially dangerous.

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:

A review of all Care Plans, Behavioural Support Plans and Wound Care Plans will be carried out by the PIC. A Care Plan and Documentation training will be carried out in the coming weeks by the Operations Manager and a further follow up training will be scheduled by the PIC to ensure consistency.

Re-training for Epic Care Plan software use will also be scheduled in September to ensure familiarity with the system.

Proposed Timescale: 30/10/2016

Theme:

Effective care and support

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

Inspectors saw that residents had been reviewed by a speech and language therapist when required however the care plan had not been updated to reflect the recommendations changes made.

8. 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 were updated to reflect the recommendations of the Speech and Language Therapist by 7th September 2016.

Proposed Timescale: 07/09/2016

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:

Recommendations for improvement identified and relayed to the provider nominee, person in charge and operations manager included:

- Storage arrangements, as outlined in outcome 8
- Dual use of oratory as a visitor's room
- The layout of furniture in twin rooms and close proximity of beds.

9. 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:

The Visitors room / Oratory has always been a dual purpose room at St. Peters over the last 15 years. This has never had any impact on Resident care or the successful operation of the home. In our planned extension we will have a separate Visitors room and this is due for completion in Q3 2017.

We will review the layout of the furniture and beds in our twin rooms and implement improvements by October 14th 2016. Please also see action 6 response.

Proposed Timescale: October 14th 2016 and Q3 2017.

Proposed Timescale: 30/09/2017

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Staff training records showed that all staff had not completed up to date training in cardio pulmonary resuscitation (CPR) to ensure an appropriate response to emergency events and advanced care directives.

Two staff did not have a date for fire safety training.

10. 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:

All staff receive fire safety induction training and fire safety training (including refresher training). A date for CPR Training and Fire Safety had been scheduled and confirmed since the last inspection. CPR (September 12th and 21st) Fire Safety (October 19th).

Proposed Timescale: September 16th and October 19th, 2016

Proposed Timescale: 19/10/2016

Theme:
Workforce

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

Records and staff files viewed by inspectors indicated that staff were not subject to frequent reviews following their employment in the centre, as well as annual appraisals thereafter.

A formal process of carrying out exit interviews with staff leaving employment was recommended by inspectors to inform staff retention and development programmes.

11. 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:

Staff Appraisals had now been scheduled from the 5th of September 2016. PIC will ensure that this will be maintained and all reviews will be documented going forward. Staff who have left had been met by PIC prior to finishing however, a formal exit interview was not carried out. Moving forward, all staff leaving will be met by the PIC and an exit interview will be carried out either by the PIC or HR.

Proposed Timescale: 30/09/2016