<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St. Peter’s Nursing Home</th>
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</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@trinitycare.ie">stpeters@trinitycare.ie</a></td>
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<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 Unlimited Company</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Keith Robinson</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Una Fitzgerald</td>
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About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

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

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

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

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
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 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 an application to vary registration conditions. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

<table>
<thead>
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<tr>
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<td>19 July 2017 08:30</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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<tr>
<td>Outcome 02: Governance and Management</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 08: Health and Safety and Risk</td>
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<tr>
<td>Management</td>
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<tr>
<td>Outcome 09: Medication Management</td>
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<tr>
<td>Outcome 11: Health and Social Care Needs</td>
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<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 16: Residents’ Rights, Dignity and</td>
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<tr>
<td>Consultation</td>
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<tr>
<td>Outcome 18: Suitable Staffing</td>
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Summary of findings from this inspection

This report sets out the findings of a two day, announced inspection, following an application to vary registration conditions. The centre has completed an extension which will bring the total capacity to a total of 69 residents.

During the course of the inspection, the inspector met with residents, relatives, staff and the management team in the centre. The views of all were listened to, staff practices were observed and documentation maintained was reviewed. Surveys completed by residents and their relatives were also reviewed.

Overall, the inspector found that the care was delivered to a high standard by staff who knew the residents well and discharged their duties in a respectful and dignified way. The management and staff of the centre were striving to improve residents’ outcomes. A person-centered approach to care was noted. Residents were well cared for, had good access to health and social care services and expressed satisfaction with the assistance and support they received in the centre. Relatives spoken to were complimentary of the care.
Management systems are in place within the centre that define the lines of responsibility and accountability. The person in charge, along with the management team responsible for the governance, operational management and administration of services and resources demonstrated sufficient knowledge and an ability to meet regulatory requirements. The authority had received unsolicited information pertaining to the management team and staffing supervision. The allegations were not substantiated by the findings during the two day inspection.

The premises were homely, safe, suitably designed and laid out to meet the needs of the residents. The additional rooms added by the building extension are finished to a high standard and the design and layout of the centre is suitable for its stated purpose. This is discussed in detail within the body of the report. The plans to schedule admissions of new residents was discussed and agreed with the clinical operations manager and the person in charge. There was good access to resources in the centre with an appropriate stock of equipment and mattresses. The clinical operations manager assured the inspector that the centre was well resourced in order to ensure the delivery of care as described in the statement of purpose. There was a new person in charge of the centre since the last inspection. The person in charge had good knowledge of current residents’ care and conditions. Overall the management had good governance systems and arrangements in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

The person in charge confirmed that all staff have completed Garda vetting.

The actions required following the last inspection (11 in total) had been addressed. However, further work is required to ensure that there is adequate storage. Of the eight outcomes inspected six were found to be compliant/substantially compliant. The findings are discussed throughout the report and areas for improvement are outlined in the action plan at the end of the report.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

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 inspector found that there was a clearly defined management structure that identifies the lines of authority and accountability, specifies roles and details responsibilities for the areas of care provision. This was outlined in the statement of purpose and staff were familiar with their duty to report to line management.

Management had systems in place to capture statistical information that was collated and presented within the 2016 annual review of the quality and safety of care delivered to residents. For example, audits were carried out and analysed in relation to accidents, complaints and medication management. This information was made available to the inspector. There was good evidence that the report was utilised to inform future practice and identify areas of priority to be addressed. A record of all incidents occurring in the designated centre is maintained. The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. However, a review of the process was required to ensure that all notifiable incidents are notified to the Chief Inspector within the three day timeframe.

Conversations had by the inspector with residents and relatives during the inspection were positive in respect of the provision of care, the facilities and services provided. There was evidence of consultation with residents and their representatives in a range of areas. For example, the assessed needs of residents; the care planning and review process; involvement in social and recreational activities; meals provided and the premises. Management systems are in place to monitor the provision of care. The centre has computerized system in place since early 2016 for the recording, monitoring and documentation of resident clinical files. However, there was some further development required to ensure that the team had detailed knowledge on how to navigate the system and how to retrieve the information requested.
There are policies and procedures for the management of complaints. The Inspector was satisfied that residents are made aware of the complaints process as soon as practicable following admission. The complaints process is user friendly and accessible to all residents. There is an appeals process in place. The inspector reviewed the complaints log. Records indicated that complaints were minimal, a total of seven to date in 2017. The management of all complaints received had been investigated promptly, a record of the outcome was documented and there was also detail if the complainant was satisfied with the outcome. The centre had an appeals officer and also directed the complainant to the office of the Ombudsman if unhappy with the outcome.

**Judgment:**
Substantially Compliant

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

**Findings:**
Measures were in place to protect residents from being harmed or abused. There was a current policy which provided guidance for staff on the various types of abuse, assessment, reporting and management of allegations or incidents of elder abuse.

Staff confirmed and training records indicated that staff had attended training on the prevention, detection and response to abuse. Staff who spoke with inspectors were knowledgeable about the various types of abuse, recognising abuse, and were familiar with the reporting structures in place. There were systems in place to ensure that allegations of abuse were investigated, and that pending such investigations measures were put in place to ensure the safety and welfare of residents.

Great emphasis was placed on residents’ safety and welfare. The inspector saw that a number of measures had been taken to ensure that residents were protected and felt safe while at the same time had opportunities for maintaining independence and fulfilment. Communal areas were accessible to residents. The inspector saw that there were facilities in place to assist residents to retain their independence. For example mobility aids, hand rails on corridors and circulating areas. There was a call bell facility in all rooms that were occupied. The inspector observed throughout the two day inspection that the call bells were answered in a timely manner. This was also confirmed by the residents and families spoken with. The questionnaires also confirmed that
Residents felt safe and were protected from harm in the designated centre.

Systems and arrangements were in place for safeguarding resident’s finances and property. The centre currently acts as a pension agent for two residents. Documentation was reviewed and the administration personal confirmed that all monies are held in a separate resident account.

An aim to promote a restraint free environment in line with the national policy was described and demonstrated. A restraint policy last updated in May 2017 was available. There was no reported use of chemical restraint. Monthly reviews of bedrail use was maintained and recorded within a restraint register. Staff and records confirmed that three of the 33 residents (9%) were using bedrails that restricted movement. The restraint policy clearly defined restraint and outlined the types of restraint, assessment, checks and review practices. The inspector reviewed all three files. A consent form was signed and detail of a general practitioner involvement in the decision was evident. Care plans and evaluation records included evidence of alternatives available. Records of the duration of restraint and safety checks or releases were not consistently recorded and there was significant gaps in all three files. This was discussed with the nurse management team who actioned a plan to address the gaps as a matter of priority.

The centre has a policy on and procedures in place to support staff with working with residents who have behavioural and psychological symptoms of dementia (BPSD). This policy was informed by evidence-based practice and implemented by staff. Staff spoken with adopted a positive, person centred approach towards the management of responsive behaviours that challenge. The person in charge informed the inspector that among the current residents there was no resident that had responsive behaviours. The inspector reviewed the care plan of a resident that has a history of responsive behaviour and noted that the care plan had clearly identified the resident’s triggers and guided the clinical team on how best to manage any incidents. The computerised system in place had templates of ABC assessment charts for recording any incidents. During the inspection it was observed that staff approached this resident in a sensitive and appropriate manner and the resident responded positively to staff.

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

Findings:
The centre had policies and procedures relating to health and safety. The health and safety statement was available and a full assessment has been carried out for the new extension dated July 2017. The centre has a comprehensive risk management policy that includes items set out in Regulation 26(1). The centre had a current risk registrar that identified areas of risk within the centre and the control measures in place to minimise any negative impact on residents. A weekly clinical report is carried out detailing any areas of risk. This report is reviewed by the group clinical operations manager. Arrangements were in place for investigating and learning from audits and adverse events involving residents. The management team were involved in the review of incidents and accidents involving residents to identify the key cause or likely factors in order to inform control measures.

Arrangements, consistent with the national guidelines and standards for the prevention and control of healthcare associated infections, were in place. Staff had access to personal protective equipment such as aprons and gloves, hand washing facilities and hand sanitisers on corridors. Staff were seen using these facilities between resident contact. Signs were on display to encourage visitors to use the hand sanitisers. The cleaning schedule included the routine daily chores but also contained detail of a deep cleaning schedule. Household staff spoken to were very knowledgeable on the system in place to ensure that the cleaning regime minimises the risk of cross infection. The standard of cleanliness throughout was excellent.

Suitable arrangements were in place in relation to promoting fire safety. The fire alarm system was serviced on a quarterly basis and fire safety equipment was serviced on an annual basis. Fire safety and response equipment was provided. Fire exits were identifiable by obvious signage and exits were unobstructed to enable means of escape. Fire evacuation procedures were prominently displayed throughout the building. Staff were trained in fire safety and those who spoke with the inspector confirmed this and were knowledgeable about fire safety and evacuation procedures. A total of five simulated fire drills had been completed in the centre for 2017. A record of the drill, the scenario simulated, the persons involved, the time taken for and extent of the evacuation was detailed.

The building extension development had been the subject of a fire safety certificate application to the local Fire Department where the Fire Department had approved the proposed design of the extension and associated alterations to the building. A copy of this certificate was shown to the inspector.

**Judgment:**
Compliant

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**Outcome 09: Medication Management**
*Each resident is protected by the designated centre’s policies and procedures for medication management.*

**Theme:**
Safe care and support
Outstanding requirement(s) from previous inspection(s):  
No actions were required from the previous inspection.

Findings:  
There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. Medicine management policies were last reviewed in May 2017. Systems were in place for ordering, supply and dispensing methods. There were appropriate procedures for the delivery and collection by the pharmacy, and checking, storage, return and disposal of medicines by nurses.

A detailed audit of the medicines management system was carried out monthly by the person in charge. The centre also has an external provider that carries out an independent audit on medicine management practices and a stock control audit quarterly. A comprehensive analyses of medicine errors was in place and learning from incidents and reported errors informed improvements to protect residents.

The processes in place for the handling and checking of medicines received including controlled drugs were examined. Practices found and procedures described were in accordance with current professional guidelines and legislation.

Nursing staff were observed as they administered medicines. Residents were unhurried and reminded of the purpose of the medicines administered. Prescription and administration records were maintained in accordance with the centre’s policy and professional standards.

A system was in place for prescription review by the resident’s general practitioner and pharmacist every three months or more frequently if indicated.

Judgment:  
Compliant

Outcome 11: Health and Social Care Needs  
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:  
Effective care and support

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

Findings:
Residents’ health and care needs were met through timely access to medical treatment. Residents had good access to a general practitioner and allied healthcare professionals. The inspector focused and tracked the journey prior to and from admission of a number of resident files. The review also looked at specific aspects of care such as nutrition, wound care, mobility, access to health care and supports, medicine management, end of life care and maintenance of records.

The inspector saw good evidence that advice received from the multidisciplinary team was followed up in a timely manner. The detail of reviews carried out was clearly evident within the records. The centre had a system whereby each resident had a named key nurse. This system ensured that each care plan was person centered and guided care.

Resident files held a copy of their Common Summary Assessments (CSARS), which details assessments undertaken by professionals such as a geriatrician and members of the multidisciplinary team. On admission all residents had a comprehensive nursing assessment. The inspector observed that initial care plans were written within the 48 hour timeframe as per the regulations. There was clear evidence that all care plans are further developed over time to ensure they are person centered. The assessment process involved the use of validated tools to assess each resident’s dependency level, risk of malnutrition, level of mobility, falls risk assessment and skin integrity. Assessment outcomes were linked to care plans that were seen to be reviewed in consultation with the resident and family at intervals of three months and more frequently when clinically indicated. There was good evidence contained within the communication care plans that the resident and their family were kept updated and involved in care discussions. This was also confirmed during conversations had by the inspector with residents and family over the two day inspection.

Clinical observations such as blood pressure, pulse and weight were assessed on admission, and monthly thereafter. A care plan was developed following admission. In the sample reviewed, information following the assessment, involvement and recommendations of allied healthcare professionals was reflected. Care was seen to be delivered to each resident in accordance with their identified needs. Systems are in place to ensure that all relevant information about residents is provided and received when they are transferred to another care setting, home or hospital. For example, the computerised system generates a report that is easily accessible that captures all entries so that a detailed transfer letter specific to the resident is available.

Staff provided end of life care to residents with the support of their general practitioner and have access to specialist community palliative care services if required. Each file reviewed had an end of life care plan. This care plan is kept under regular review and was updated in consultation with the resident and where appropriate a family member. There was no resident receiving end of life care on the day of inspection. With the building renovations the centre has identified an en-suite room that will have a bed couch that will allow for families and loved ones to be accommodated overnight. Facilities for refreshment will also be available. Staff outlined how religious and cultural practices were facilitated within the centre.

Arrangements were in place to meet the nutritional and hydration needs of residents
with dementia. There were systems in place to ensure residents' nutritional needs were facilitated and monitored. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked. Nutritional and fluid intake records were maintained. Some gaps in the accuracy of the documentation on recording of fluid intake and output was seen. This was discussed with the nursing management and addressed during the inspection.

The processes in place ensure that residents do not experience poor nutrition and hydration. The Inspector saw that a choice of meals was offered and available to residents. There was a system of communication between nursing and catering staff to support residents with special dietary requirements. Any food allergies were clearly recorded along with resident's likes and dislikes. Staff sat with residents while providing encouragement or assistance with the lunch-time meal. Assistance was given to residents in a discreet and sensitive manner.

Residents were assessed to identify their risk of developing pressure related skin injuries. Residents at risk had specific equipment in place to mitigate level of risk, such as repositioning regimes and pressure relieving mattresses and cushions. There was one resident with a pressure ulcer on the day of inspection. A care plan was available but the detail did not guide practice. This was addressed during the inspection. The inspector reviewed the wound management procedures in place. Tissue viability specialist services were available to support staff with management of any residents' wounds that were deteriorating or slow to heal.

Judgment:
Compliant

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

Findings:
The inspector found that the design and layout of the centre was suitable for its stated purpose. The centre has recently had an extension added to both sides of the building. In the East wing there is an additional 13 single en-suite bedrooms and on the Caislean unit there are an additional 20 single en-suite rooms. The new extension will allow the
centre a total capacity to accommodate 69 residents. The entrance has a reception area with the person in charge office within open access to residents, relatives and staff. There are 63 single rooms and three double bedrooms. There is now a large extension added to the existing dining room, an additional sitting room, assisted bathrooms and a new clinical room. Reconfiguration of existing rooms has occurred to maximize on space available. For example, the centre now has a separated oratory and visitor’s room. The matters arising from the previous inspection were discussed and further work is required around the use of existing storage space. The inspector observed that the new east wing extension did not have storage for assisted equipment. A solution was found on the day of inspection that will not cause any structural changes to be required.

The existing bedrooms within the centre and communal rooms have all been upgraded in line with the new extension. Overall the inspector found that the areas of the centre that had been renovated were suitable for the needs of the residents.

Within the centre there was one bath. All bedrooms were en-suite with shower facilities. However, the inspector was not satisfied that staff could support the choices of residents with mobility problems who preferred a bath to a shower. This was discussed with the management team who agreed to action the installation of a specialised hoist so that residents will have the option to have a bath if preferred to having a shower.

The accommodation is of a high standard with suitable furnishings and fittings and decorated to provide a warm and homely atmosphere. Shared bedrooms have appropriate screening for residents' privacy. The environment provides residents with freedom of movement both in their individual bedrooms and in communal areas. Grab rails were in place throughout communal areas.

In preparation for the admission of new residents the provider had bought a new industrial sized washing machine and dryer to ensure that the centre can meet the demands of the increasing residents. The inspector spoke with household staff. There is an efficient system in place for the management of residents personal clothing.

The designated centre is a single story building. The new gardens in the Caislean unit were completed and residents have free access to manicured gardens. Work is currently underway on the installation of sensory gardens that are due completion on the 31st July 2017. The inspector had concerns that a number of the bedrooms were at risk of resident privacy being compromised by individuals walking outside on the footpaths. Reassurance was given that the decision had been taken to give all new residents the option to have blinds installed or film placed on the outside of the windows that would ensure their view outside was not obstructed.

Judgment:
Non Compliant - Moderate

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. A residents' meeting is held by the activities coordinator and the person in charge attends part of the meeting. Resident surveys are carried out frequently. The last survey dated 14th June 2017 evidenced good levels of satisfaction.

Information in relation to the services of an independent advocate was available to residents. Currently there is one resident availing of this service. Residents’ independence and autonomy was promoted. Outings, links and access to the local town were also facilitated to enhance engagement in the wider community. The dining room notice board has multiple photos of the most recent outings. For residents that are not able to travel the centre has linked with local groups who come into the centre and provide entertainment. Residents had options to meet visitors in a private or communal area based on their assessed needs.

Residents' bedrooms were personalised with family photographs and memorabilia were clearly on view. The inspector established from speaking with residents, relatives and staff that opportunities to maintain personal relationships with family and friends in the wider community was encouraged and facilitated. Visitors were unrestricted. A record of visitors was maintained. Arrangements were provided for residents to attend external appointments or family occasions and maintain links with the wider community. Transport and escort arrangements were facilitated for residents to access events and the wider community. Overall, the arrangements in place promoted social inclusion, engagement and access to external facilities.

Communication aids, telephones and newspapers were available to residents. Residents are facilitated to exercise their civil, political and religious rights. The centre has access to local clergy. The management are currently reviewing the option to have daily mass streamed from the local church.

The inspector saw that residents' privacy and dignity was respected and personal care was provided appropriately. Residents were seen to be well groomed and dressed in an appropriate manner with clothes and personal effects of their choosing. Residents who spoke with the inspector and those who completed questionnaires said they were respected, consulted with and well cared for by pleasant and kind staff. Relatives who spoke with the inspector were also very complimentary of the staff and care provision.
Each resident has opportunities to participate in activities that are meaningful and purposeful to their needs, interests and capacity. The activities coordinator has a detailed record that identified how each resident's individual care needs are met. The weekly activities timetable was reviewed. The schedule is varied and extensive. With the planned increase in resident numbers the allocated hours will also increase to ensure that the staff can continue to deliver activities that are meeting all future residents needs.

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

Findings:
The actual and planned rosters for staff was reviewed. The inspector found that staffing levels and skill mix were sufficient to meet the needs of residents. Staff spoken to confirmed that they had sufficient time to carry out their duties and responsibilities. The person in charge explained the systems in place to supervise staff. Residents spoken to confirmed that they felt their care needs were met by staff. Recruitment and induction procedures were in place. The centre had a process for staff appraisals in place. Staff spoken with felt supported by the management team.

Evidence of current professional registration for all registered nurses was seen by the inspector. Training records showed that extensive training had been undertaken and staff spoken with confirmed this. Training included in house mandatory training on safeguarding and safety, patient moving and handling, fire safety and cardio pulmonary resuscitation. All staff nurses had additional requirements such as medication management and dementia training. The training matrix evidenced that all mandatory training was up to date.

All documents as required by Schedule 2 of the regulations for staff were maintained.

The proposed staffing whole time equivalent that is planned to meet the needs of 69
residents was discussed. The increases proposed across all departments was reviewed. Post review of the planned rosters it was agreed with the management team that when the resident numbers reach 44 the clinical nurse manager supernumerary hours will increase from 0.5 whole time equivalent hours to full time supernumerary. This increase will ensure that the comprehensive audit schedule in place that monitors the service delivered can be sustained and that resident care is not compromised. This arrangement will remain in place until the successful appointment of an Assistant Director of Nursing. The management team agreed on an admission schedule of a maximum of four residents per week Monday through Thursday.

**Judgment:**
Compliant

**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:**

Una Fitzgerald
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report¹

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<td>OSV-0000122</td>
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<td>18 and 19 July 2017</td>
</tr>
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<td>Date of response:</td>
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Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

Outcome 02: Governance and Management

Theme: Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre has computerized system in place since early 2016 for the recording, monitoring and documentation of resident clinical files. However there was some further development required to ensure that the team had detailed knowledge on how to navigate the system and on how to retrieve the information requested.

1. Action Required:

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
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 centre has purchased a training system specific to the computerised system to further develop the team’s knowledge on how to navigate the system and how to retrieve information requested. All nursing staff will undertake this training.

**Proposed Timescale:** 30/09/2017

**Theme:**
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Management had systems in place to capture statistical information. However a review of the process was required to ensure that all notifiable incidents are notified to the Chief Inspector within the three day timeframe.

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

**Please state the actions you have taken or are planning to take:**
Management have put systems in place that are reviewed and monitored by the Director of Nursing and the Clinical Operations manager to ensure that all notifiable incidents are reported to the chief inspector within specified time frames.

**Proposed Timescale:** 28/07/2017

**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:
Records of the duration of restraint and safety checks or releases were not consistently recorded and there was significant gaps in all three files. This was discussed with the nurse management team who actioned a plan to address the gaps as a matter of priority.

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

**Please state the actions you have taken or are planning to take:**
Management have put processes in place to ensure that all residents who have restraints applied have safety checks and or releases consistently carried out and recorded as per local and national policies. These processes are reviewed daily by the Director of Nursing or assigned person in charge.

**Proposed Timescale:** 19/07/2017

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### Outcome 12: Safe and Suitable Premises

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The matters arising from the previous inspection were discussed and further work is required around the use of existing storage space. The inspector observed that the new east wing extension did not have adequate storage for assisted equipment.

4. **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:**
Management team have identified a suitable area that will provide adequate storage for assisted equipment for residents residing in the newly developed East wing.

**Proposed Timescale:** 30/09/2017

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Within the centre there was one bath. All bedrooms were ensuite with shower facilities. Staff could not support the choices of residents with mobility problems who preferred a bath to a shower. This was discussed with the management team who agreed to action the installation of a specialised hoist so that residents will have the option to have a bath if preferred to having a shower.

5. **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 management team will undertake a full review of the current bathing facilities and
together with Trinity Care’s Occupational and Physiotherapist decide and act on the
appropriate measures needed to ensure that residents with mobility problems have the
option to have a bath if preferred to having a shower.

Proposed Timescale: 31/10/2017