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:	0122
Centre address:	Sea Road Castlebellingham, County Louth
Telephone number:	042-9382106
Email address:	stpeters@guardianhealthcare.ie
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Guardian Healthcare Ltd
Person authorised to act on behalf of the provider:	Keith Robinson
Person in charge:	Eileen Dullaghan
Date of inspection:	23 and 24 July 2013
Time inspection took place:	**Day-1 Start:** 09:30 hrs **Completion:** 17:00 hrs **Day-2 Start:** 10:00 hrs **Completion:** 15:10 hrs
Lead inspector:	Sheila McKevitt
Support inspector(s):	Sonia McCague
Type of inspection	☒ **announced** ☐ **unannounced**
Number of residents on the date of inspection:	39
Number of vacancies on the date of inspection:	0

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 their 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
- 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. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Summary of compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) 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, in which all of the 18 outcomes were inspected against. The purpose of the inspection was:

- ☒ to inform a registration decision
- ☒ to inform a registration renewal decision
- ☐ to monitor ongoing compliance with Regulations and Standards
- ☐ following an application to vary registration conditions
- ☐ following a notification of a significant incident or event
- ☐ following a notification of a change in person in charge
- ☐ following information received in relation to a concern/complaint

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

Outcome	Inspected
Outcome 1: Statement of Purpose	☒
Outcome 2: Contract for the Provision of Services	☒
Outcome 3: Suitable Person in Charge	☒
Outcome 4: Records and documentation to be kept at a designated centres	☒
Outcome 5: Absence of the person in charge	☒
Outcome 6: Safeguarding and Safety	☒
Outcome 7: Health and Safety and Risk Management	☒
Outcome 8: Medication Management	☒
Outcome 9: Notification of Incidents	☒
Outcome 10: Reviewing and improving the quality and safety of care	☒
Outcome 11: Health and Social Care Needs	☒
Outcome 12: Safe and Suitable Premises	☒
Outcome 13: Complaints procedures	☒
Outcome 14: End of Life Care	☒
Outcome 15: Food and Nutrition	☒
Outcome 16: Residents' Rights, Dignity and Consultation	☒
Outcome 17: Residents' clothing and personal property and possessions	☒
Outcome 18: Suitable Staffing	☒

This registration inspection was announced and took place over two days. As part of the inspection inspectors met with residents, relatives, and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs,complaints file, policies and procedures and staff files.

Prior to the inspection, inspectors reviewed written evidence from a suitably qualified person confirming the building meets all the statutory requirements of the fire and planning authorities in relation to the use of the building as residential centre for older people. All documents submitted by the provider, for the purposes of application to register were found to be satisfactory. The inspectors confirmed that

the provider had fully addressed all five actions from the last monitoring inspection which took place on 02 February 2012.

Overall, the inspectors found the provider, person in charge, had undertaken some preparation for the registration inspection and demonstrated this by meeting 13 of 18 Outcomes. The provider and the person in charge were found to be operating in compliance with the conditions of registration. Athough, not yet in substantial compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

The five outcomes not met related to resident general records, assessments, care plans and daily evaluation of care provided. In addition, policies and procedures did not did not reflect best practice guidelines, reflect practices in the centre and/or the legislative requirements. The complaints policy, management of compliants and records held were not in line with legislative requirements. Medication management required review as did practices in relation to systems in place to ensure quality care improvements.

Section 41(1)(c) of the Health Act 2007
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Theme: Leadership, Governance and Management
Effective governance, leadership and management, in keeping with the size and complexity of the service, are fundamental prerequisites for the sustainable delivery of safe, effective person-centred care and support.

Outcome 1
There is a written statement of purpose that accurately describes the service 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. **References:** Regulation 5: Statement of Purpose Standard 28: Purpose and Function
Action(s) required from previous inspection: The action(s) required from the previous inspection were satisfactorily implemented.

Inspection findings

The inspector reviewed the statement of purpose and found that it described the services and facilities provided in the centre and the information was in accordance with Schedule 1 of the Regulations. The written statement of purpose reflected the

most recent registration certificate issued to the provider on 22 March 2011 following an application to register the designated centre. The inspector noted minor adjustments were required to the organisational structure chart on page 11 to ensure it accurately reflected the organisational structure in place. An amended statement of purpose was submitted on 25 July 2013.

Outcome 2
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.

References:
Regulation 28: Contract for the Provision of Services
Standard 1: Information
Standard 7: Contract/Statement of Terms and Conditions

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Samples of contracts of care were reviewed. All residents had agreed a contract of care with the provider which included details of the services to be provided for that resident and the main fee to be charged. They also included the fees and costs of additional services as outlined in the application for registration. The inspector had a discussion with the provider regarding the requirement for the issuing of new contracts of care to each resident when the new company has been registered as the provider for the centre.

Outcome 3
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

References:
Regulation 15: Person in Charge
Standard 27: Operational Management

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The person in charge was on duty during the inspection. She has worked in the centre since 2012. Details of her nursing experience included 3/6 years of working with older people. She works full-time, is a registered general nurse and has a post graduate qualification in management and Gerontology. She is supported in her role

by a clinical nurse manager who manages the centre in her absence and by the provider.

The person in charge has line management responsibilities for the nursing, care staff, administration, household, catering and maintenance.

Outcome 4
The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) 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 2009 (as amended).

References:
Regulations 21-25: The records to be kept in a designated centre
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

Inspection findings:
**Where "Improvements required" is indicated, full details of actions required are in the Action Plan at the end of the report.*

Residents' Guide

Substantial compliance ☒ Improvements required * ☐

Records in relation to residents (Schedule 3)

Substantial compliance ☐ Improvements required * ☒

Residents' records were not specific or reliable. For example,

- re-positioning charts were been completed retrospectively
- fluid balance charts were not totaled at the end of a 24 hour period
- shower lists were used rather than person centered care plans
- do not resuscitate orders were not reviewed for over a year
- all residents whose assessment identified a care need did not have a corresponding care plan. Prescribed plans of care by visiting disciplines were not updated in the resident care plan. Therefore, it was not clear from the records if said treatment had been delivered
- medication errors were not recorded.

General Records (Schedule 4)

Substantial compliance ☒ Improvements required * ☐

Operating Policies and Procedures (Schedule 5)

Substantial compliance ☐ Improvements required * ☒

All need to be reviewed as those policies reviewed on and post inspection did not reflect best practice guidelines, reflect practices in the centre and/or the legislative requirements.

For example, the elder abuse policy did not provide clear guidance to staff. It did not mention informing the residents' next of kin or the Authority. On page 6 it refers to the operations manager, who is not reflected in the statement of purpose. It does not contain details of the senior social worker for the area.

The missing person's policy did not reflect practices in the centre, the complaints policy was not specific to the centre and the nutritional policy did not provide clear guidance to staff.

Directory of Residents

Substantial compliance ☒ Improvements required * ☐

Staffing Records

Substantial compliance ☒ Improvements required * ☐

Medical Records

Substantial compliance ☒ Improvements required * ☐

Insurance Cover

Substantial compliance ☒ Improvements required * ☐

Outcome 5

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

References:

Regulation 37: Notification of periods when the Person in Charge is absent from a Designated Centre
Regulation 38: Notification of the procedures and arrangements for periods when the person in charge is absent from a Designated Centre
Standard 27: Operational Management

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The person in charge had not been absent for more than 28 days which required notification to the Authority. The person in charge was aware of her reporting requirements to submit appropriate notifications. As mentioned under Outcome 3, the clinical nurse manager was nominated key senior manager to take charge in the absence of the person in charge.

Theme: Safe care and support

Safe care and support recognises that the safety of service users is paramount. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers.

In a safe service, a focus on quality and safety improvement becomes part of a service-wide culture and is embedded in the service's daily practices and processes rather than being viewed or undertaken as a separate activity.

To achieve a culture of quality and safety everyone in the service has a responsibility to identify and manage risk and use evidence-based decision-making to maximise the safety outcomes for service users.

Outcome 6

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.

References:

Regulation 6: General Welfare and Protection
Standard 8: Protection
Standard 9: The Resident's Finances

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Staff spoken to on the day of inspection was aware of the types of elder abuse and their responsibilities in reporting suspected elder abuse. Records reviewed confirmed that staff had received training on identifying and responding to elder abuse. Garda Síochána vetting was in place for staff. This was evidenced by a review of a sample of four staff files.

Residents spoken to confirmed that they felt safe in the centre. Entrance and exit doors were secure. There was a member of staff on the reception desk from 9am to 5pm, where all visitors to the centre were asked to sign in.

Safe procedures were followed with clear and concise records held for the management of residents' petty cash.

As mentioned under Outcome 4, the elder abuse policy needed to be reviewed.

Outcome 7
The health and safety of residents, visitors and staff is promoted and protected.

References:
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Action(s) required from previous inspection:

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

Inspection findings

The risk management policy had been reviewed since the last inspection. It now included a clear policy to guide staff in the event of any incident of violence, aggression, self harm and assault and outlined how to undertake a risk assessment. A risk register had been completed and was continually updated by the management team. Risks identified at the last inspection had been addressed. The smoking room door had an opening device installed, incontinence pads were stored in a cupboard within the toilets, windows opening into the internal courtyards were now restricted and records showed that all staff nurses had registered with An Bord Altranais agus Cnáimhseachais na hÉireann for 2013. A culture of managing any identified risk was evident and resident safety was a management priority. A health and safety policy and safety statement was in place and it had been updated by qualified personnel in August 2012.

The management team had introduced a ribbon system whereby residents assessed as at risk of falling wore a red coloured ribbon and those at risk of absconsion wore a greeen coloured ribbon. The purpose of the system was to alert staff, other residents and relatives that the residents were at risk in a discreet manner. The residents guide was being updated to include details about the ribbon system.

There was a missing person policy which included clear procedures to guide staff should a resident be reported as missing. A policy was in place to guide staff in the event of any incident of violence, aggression, self harm and assault.

An emergency plan was in place to outline clear procedures to follow in the event of loss of electric power, flood, or security concerns. However, as gas leak was not included the policy was amended to include gas leak and submitted to the inspectors prior to inspection being completed. Inspectors spoke to staff and found they were familiar with the contents of the emergency plan, reporting structures in case of an emergency and where residents could be evacuated to.

Residents confirmed to inspectors in conversations that they felt safe in their day-to-day life at the centre and enjoyed the secure internal courtyards.

A centre-specific infection prevention and control policies and procedures were found to be in place. Hand-washing and drying facilities and hand disinfectant gels were available at the reception.

The fire alarm, fire fighting equipment and emergency lighting was maintained and records reviewed showed they were checked on a frequent basis by professional personnel. There was evidence to show that all staff had attended fire safety and evacuation training and all took part in at least one fire drill in 2013. Means of escape were clear and unobstructed; these were checked daily by staff. The procedures to be followed in the event of fire were displayed in a number of prominent locations and staff spoken with had a good knowledge of the procedure to follow in the event of a fire.

Outcome 8
Each resident is protected by the designated centres' policies and procedures for medication management.

References:
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Inspectors reviewed the medication management policy and noted that it included the procedure for prescribing, administering, recording, safekeeping and disposal of unused or out of date medications.

Inspectors reviewed medication management practice and found administration of medication was not safe or in line with An Bord Altranais agus Cnáimhseachais na hÉireann guidance to nurses and midwives as staff nurses were not checking the right time. The prescription charts did not include the times medications were to be administered at and the staff nurses were not documenting the time they administered medications for either regular or/and PRN (as required) medications. In addition, when staff signed to say they administered PRN medications, where for

example a dose of 2.5 - 5mls was prescribed, staff did not record the dose they administered to the resident.

Where residents' were administered a form of chemical restraint it was not clearly linked with an episode of behaviour which was challenging. Inspectors also noted that on two separate occasions one resident did not receive a prescribed medication, there was no recorded evidence to indicate why the medication had been omitted and a medication variance report form had not been completed. In addition, oxygen was not prescribed for two residents who were receiving same.

A record of medications received and returned to and from pharmacy was maintained. At each shift change the medications that required strict control measures (MDAs) were checked and counted. The inspector found record keeping was to a high standard in this area and in line with best practice. The pharmacy delivered a pre-packaged medication system which was checked by two staff members on delivery.

A medication audit was carried out by external personnel together with the management team in May 2013 and staff nurses had signed to say they had read the results of the audit. However, there was no evidence available to indicate that the recommendations from the audit had been implemented.

Outcome 9
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

References:
Regulation 36: Notification of Incidents
Standard 29: Management Systems
Standard 30: Quality Assurance and Continuous Improvement
Standard 32: Register and Residents' Records

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Inspectors cross referenced notifications submitted to the Authority since the last inspection with records of all accidents and incidents recorded in the centre since the last inspection. All serious accidents and incidents had been notified to the Authority by the person in charge in a timely manner.

Theme: Effective care and support
The fundamental principle of effective care and support is that it consistently delivers the best achievable outcomes for people using a service within the context of that service and resources available to it. This is achieved by using best available national and international evidence and ongoing evaluation of service-user outcomes to

determine the effectiveness of the design and delivery of care and support. How this care and support is designed and delivered should meet service users' assessed needs in a timely manner, while balancing the needs of other service users.

Outcome 10
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

References:
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The management team had completed audits on the following areas of practice in 2013 - medication management, food and nutrition, hand-washing, falls, infection control practices, environment and nursing documentation. These were reviewed on inspection. Inspectors found the audit tools used for some of the audits were poor and this lead to a minimum amount of relevant data being gathered during the audit process. For example, the data gathered in the falls audit did not include where the falls occurred or whether the resident was supervised at the time of the fall and as mentioned under Outcome 8, a medication management audit conducted in May 2013 had not picked up that there were no times recorded on the medication prescription and/or administration charts.

In addition, inspectors found that data gathered from some audits had not been analysed. For example, the audit carried out by the catering company had not been analysed nor had the results of the audit on nursing care plans. For those audits where data had been analysed and recommendations made there was no evidence that the recommendations had been acted upon. For, example, the infection control audit made a number of recommendations which had not been acted upon. Therefore, it was not clear if audits completed to date had lead to an improvement in the quality of care or to the life of the resident living in the centre.

A bi-monthly audit report is submitted to the provider. It was last done in May 2013 and showed positive results on practices in the centre. However, it was not clear where recommendations were made or where there was room for improvement what actions had be taken.

Outcome 11
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. 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.

References:
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Residents and their relatives stated they felt their healthcare needs were being met and confirmed that they were facilitated to access their general practitioner (GP) and allied health professionals. A review of a number of residents' documentation showed that they had been referred to allied health professionals without delay.

Activities were provided by activity staff. A timetable displayed what activities were planned for the week and daily activities were displayed in the front foyer. The residents spoken with were satisfied with same.

Wound records were clear and concise and reflected best practice guidelines and the centres own wound management policy.

Nursing documentation required improvements. Inspectors reviewed a number of residents met on inspection and found resident assessments were not always completed accurately. For example, one residents' nutritional assessment recorded was not accurate and not referenced or reflected in the residents' care plan. Care plans were not updated to reflect visiting allied health professionals recommendations for treatment. This was noted in two different residents' files. Due to care plans not being updated the recommendations made were not being evaluated by staff nurses. Therefore, it was not evident if the treatment recommended by the visiting health professionals was being or had been delivered to the resident.

Care provided was not reflective of that described by nursing staff in the residents care plan. Inspectors observed one resident being assisted at mealtime by their next of kin, who was also a resident with a cognitive impairment, although the residents' nursing care plan stated on 14 July 2013 stated that the resident needed to be supervised when eating as a severe episode of choking had occurred and the resident was awaiting review by a speech and language therapist.

In addition, inspectors noted that records of care being delivered were completed retrospectively, for example, re-positioning charts, so they did not provide a true picture of actual care given. Other nursing record such as fluid balance charts were not totaled at the end of a 24 hour period and not evaluated on by staff nurses. Other records, such as a shower list would not be required if resident care plans were specific and person centered. The evaluation of daily care given was not reflective of the care plan or care actually given.

Inspectors found that do not resuscitate orders were not reviewed for over a year and death and dying/end of life assessments were not always completed with residents/or their next of kin following their admission to the centre.

Outcome 12
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. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Action(s) required from previous inspection:

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

Inspection findings

Inspectors found the centre to be clean and tidy. Residents' confirmed their satisfaction with the level of cleaning of both their personal space and the communal areas.

An issue from the last inspection had been addressed and a suitable work surface was now available in the laundry room. Floor covering throughout the centre appeared safe and intact. Residents had independent access to two internal courtyards. The premises were found to reflect the description outlined in the centre's statement of purpose.

Inspectors found the centre had a good supply of equipment to meet the needs of residents and records showed that this equipment was serviced on a regular basis.

The mattresses on the bed frame of some residents living in the centre was not appropriately positioned to ensure they had a comfortable night's sleep.

Theme: Person-centred care and support
Person-centred care and support has service users at the centre of all that the service does. It does this by advocating for the needs of service users, protecting their rights, respecting their values, preferences and diversity and actively involving them in the provision of care. Person-centred care and support promotes kindness, consideration and respect for service users' dignity, privacy and autonomy.

Outcome 13
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.

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Inspectors spoke with residents and relatives who were clear about who they would complain to if they had a complaint. Both felt their complaints were heard and dealt with. However, inspectors found that the complaints policy did not reflect the legislative requirements as it did not identify who was to oversee the complaints. A review of the complaints file confirmed that they were being addressed promptly. However, the complaints file did not contain records detailing the investigation and outcome of the complaint and whether or not the resident was satisfied for each complaint on file as required by the legislation.

Inspectors were informed by a resident of a complaint made which had not been addressed to his satisfaction. The resident stated the same complaint was made on at least two occasions. However, there was no record within the complaints file. Management confirmed post this inspection that they had investigated the issue. However, it remained unclear what the outcome of complaint was and whether the complainant is now satisfied.

Outcome 14
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.

References:
Regulation 14: End of Life Care
Standard 16: End of Life Care

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

There was no residents' receiving end of life care at the time of this inspection. However, access to Community Palliative Care Services was available to support residents requiring their services. This was confirmed by visitor who stated their relative had been assessed by the palliative care team for pain relief. There was an Oratory available for use by residents and their families.

Relatives are facilitated to stay overnight with residents receiving end of life care. A remembrance service for deceased residents is an annual event. As mentioned under Outcome 11, end of life assessments were not always completed.

Outcome 15
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 discreet and sensitive manner.

References:
Regulation 20: Food and Nutrition
Standard 19: Meals and Mealtimes

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspector observed lunch time service in the dining room. Residents told inspector they enjoyed the food and the choices available to them. The dining room was appropriately furnished and welcoming. Table settings were pleasant and included condiment, napkins and appropriate place settings for all residents.

Residents were offered a choice at lunch time and obtained their preferred food choices. Staff spoke to residents throughout attending to their requests during the meal. The inspector was satisfied the mealtime experience was enjoyed by residents who took their meals in the dining room and to those who ate their meal in their bedroom. Appropriate assistance was offered to residents who required assistance in both their own room and in the dining room. The Inspector observed that a small number of residents were assisted to eat their lunch one of the two sitting rooms. Inspectors observed that this small number of residents' spent a long period of their day in this sitting room. It was not clear why they were not brought to the dining room to enjoy the dining experience and it was not reflected in their care plan.

Documentation showed that each resident's weight was checked on a monthly basis or more regularly if required. Nutrition assessments were used to identify residents at risk and monitor progress with nutritional supplementation. There was a policy in place to guide and inform staff on the procedures to ensure residents' nutritional and hydration needs were met. However, as mentioned under Outcome 4, this needed to be reviewed.

Outcome 16
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.

References:
Regulation 10: Residents' Rights, Dignity and Consultation
Regulation 11: Communication
Regulation 12: Visits
Standard 2: Consultation and Participation
Standard 4: Privacy and Dignity
Standard 5: Civil, Political, Religious Rights
Standard 17: Autonomy and Independence
Standard 18: Routines and Expectations
Standard 20: Social Contacts

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

There were policies in place to address communication in the centre including the communication needs of residents'. Inspectors saw several examples that demonstrated that residents were facilitated and encouraged to communicate. As evidenced under Outcome 10, their views were sought through conducting audits. Minutes of residents' meetings were available for review.

Inspectors saw residents' taking part a variety of activities. A range of interests were facilitated. A programme was in place and displayed in the centre. Staff kept records of the activities residents' took part in and their level of participation. There were also specific activity sessions targeted towards residents with dementia where personal acknowledgement, sensory and music prompts were used to help their recollections and memory recall. Residents confirmed that they were treated with respect and dignity and said that they felt valued.

Inspectors observed that residents knew the person in charge and provider by their first name and observed interactions between all staff and residents' was friendly and positive.

Outcome 17
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.

References:
Regulation 7: Residents' Personal Property and Possessions
Regulation 13: Clothing
Standard 4: Privacy and Dignity
Standard 17: Autonomy and Independence

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The policy on personal belongings had been reviewed and updated by the person in charge. Resident clothing was individually labelled by laundry staff on admission and any new clothing brought in thereafter was also sent to the laundry for labelling. Inspectors saw and residents' confirmed that they had plenty of space to store personal possessions. Residents confirmed that a lockable storage area was available to them if they wanted it and this was reflected in the policy.

A record of their personal possessions was logged on admission and was now being kept up-to-date for all residents' and was not signed by the resident/their relative.

Theme: Workforce
The workforce providing a health and social care and support service consists of all the people who work in, for, or with the service provider and they are all integral to the delivery of a high quality, person-centred and safe service. Service providers must be able to assure the public, service users and their workforce that everyone working in the service is contributing to a high quality safe service.

Outcome 18
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.

References:

Regulation 16: Staffing
Regulation 17: Training and Staff Development
Regulation 18: Recruitment
Regulation 34: Volunteers
Standard 22: Recruitment

Standard 23: Staffing Levels and Qualifications Standard 24: Training and Supervision
Action(s) required from previous inspection: The action(s) required from the previous inspection were satisfactorily implemented.

Inspection findings

Inspectors were satisfied that the staffing levels and skill mix were now adequate to meet the needs of residents. Residents spoken with confirmed that they did not have to wait for long periods to have their call bell to be answered. There was a key worker system in place, whereby each resident was allocated a staff nurse and a career. This system leads somewhat to continuity in care. Residents who completed pre-inspection questionnaires were satisfied with current staffing levels.

Staff spoken with confirmed they had all the required mandatory training in place and records provided to inspectors post inspection confirmed this. They also confirmed they had received training in Dementia care since the last inspection. The person in charge and clinical nurse manager were currently attending a course on Dementia care.

A selection of staff files reviewed showed that staff files were in compliance with Schedule 2 of the Regulations.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider, the person in charge, and the nurse manager to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements
The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:

Sheila McKevitt
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

15 August 2013

Recommendations

The mattresses on the bed frame of a shared bed in the centre need to be reviewed/changed to ensure maximum comfort for both residents' while in bed.

Providers Response

The company supplying the mattresses have been consulted and an underlay mattress has been introduced on trial.

Timescale

30 September 2013

Health Information and Quality Authority
Regulation Directorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report *

Centre Name:	St. Peter's Nursing Home
Centre ID:	0122
Date of inspection:	23 and 24 July 2013
Date of response:	02 September 2013

Requirements

These requirements set out the actions that must be taken to meet the requirements of the Health Act 2007 as amended, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Theme: Governance, Leadership and Management

Outcome 4: Records and documentation to be kept at a designated centre

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

General nursing care and medical records required improvements. For example:
- re-positioning charts were been completed retrospectively
- fliud balance charts were not totalled at the end of a 24 hour period
- shower lists were used rather then person-centred care plans.
- do not resusitate orders were not reviewed for over a year.

Action required:

Keep the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) of the Regulations up-to-date and in good order and in a safe and secure place.

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

Reference:
Health Act, 2007
Regulation 22: Maintenance of Records
Standard 32: Register and Residents' Records

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
The repositioning chart has been amended. The staff member allocated to carry out the repositioning of the resident will sign the repositioning chart when repositioning has been carried out and this will be reflected in our policy.	30 September 2013
Our policy is that all fluid balance charts are calculated by the night nurse each morning. Recording charts are calculated using the 24 hr clock. Charts are calculated from 08.00 hrs/am to 08.00 hrs/ am (over a 24hr period) This will be reflected in the policy. In this occurence there was an oversight by the Nurse on night duty. This has been brought to her attention.	30 September 2013
Residents care in relation to their personal hygiene is now documented in their individual Care Plan and shower lists have ceased.	Completed
Do Not Resusitate Guidelines have been reviewed and updated to reflect the changes to practice.	Completed
Do Not Resusitate Orders are presently being reviewed in a cycle and will be reviewed three monthly or sooner if required involving the resident/Family, Nurse and GP.	30 October 2013

Outcome 4: Records and documentation to be kept at a designated centre

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

There was no times on medication prescription charts.

The times medications were administered were not being recorded by nurses.

Medication errors were not recorded.

The dosage of the drug administered was not always recorded.

Oxygen was not prescribed for two residents who were receiving same.

Action required:

Maintain, in a safe and accessible place, a record of each drug and medicine administered in respect of each resident, giving the date of the prescription, dosage, name of the drug or medicine, method of administration, signed and dated by a medical practitioner and the nurse administering the drugs and medicines in accordance with any relevant professional guidelines.

Action required:

Maintain, in a safe and accessible place, a record of any medication errors or adverse reactions in relation to each resident.

Reference:

Health Act, 2007
Regulation 25: Medical Records
Standard 13: Healthcare
Standard 14: Medication Management
Standard 15: Medication Monitoring

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
Staff previously administered medication as per medication prescription sheet, Morning, Lunch, Tea and Bed time. Prescription Sheets are now amended to give specific administration times;09.00hrs,14.00,18.00hrs and 21.00hrs. Our G.P. has been requested to commence signing these medication prescription sheets and identifying times for administration. The nursing administration sheet now has times of admininstration using the 24hr clock.	30 September 2013
The GP has been asked to cease the practice of prescribing a varience in PRN medication eg, 2mls or 5mls. He has been asked to prescribe a specific dose of medication and has agreed to same.	Completed
Administration of Medications Policy will be updated to indicate specific times as indicated above and any other changes to practice will be reflected in the policy .	30 September 2013
Any changes will be brought to the attention of all nurses. All nurses completed the ABA E learning Medication Management on line in 2012. Nurses will update this training.	31 October 2013
A drug which was prescribed for a resident and administered as	Completed

prescribed had not been signed as given. This has now been recorded as a medication error. The template for recording medicatiosn errors used in St Peter's since 2012 is approved by HSE and NHI. Medication errors and adverse reactions are now maintained in a specific file which is safe and accessible Medication Management audits will continue to be carried out two monthly. The audit tool is under review with our pharmacist to include administration times of medication and specific PRN dosages are prescribed. Oxygen has been prescribed for the two residents in question.	 30 October 2013 Completed

Outcome 4: Records and documentation to be kept at a designated centre

The provider is failing to comply with a regulatory requirement in the following respect: Policies reviewed on and post inspection did not reflect best practice guidelines, reflect practices in the centre and/or the legislative requirements.
Action required: Put in place all of the written and operational policies listed in Schedule 5 of the Regulations.
Action required: Review all the written operational policies and procedures of the designated centre on the recommendation of the Chief Inspector and at least every three years.
Reference: Health Act, 2007 Regulation 27: Operating Policies and Procedures Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Schedule 5 Policies are under review by a working group involving the Directors of Nursing within Trinity Care. Policies will be amended to reflect best practice guidelines and legislative requirements. The responsible person will be the PIC. All policies will be reviewed two yearly or sooner as required.	 30 November 2013

Priority will be given to the policies identified in the body of this report.	

Theme: Safe care and support

Outcome 8: Medication management

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

Nurses were not administering medications to residents in accordance with the centres policies as they were not checking the time of administration and therefore were not administering medications in line with with An Bord Altranais agus Cnáimhseachais na hÉireann guidance to nurses and midwives.

Action required:

Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

Reference:

Health Act, 2007
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Medication Management audits will continue to be carried out two monthly to ensure ABA guidlines are being adhered to. The audit tool is under review with pharmacist to include administration times are as per the 24 hour clock PRN Prescriptions have specific dose prescribed. An appropriate scoring system will be devised on this tool. All nurses will complete again the ABA medication management e-learning. Competency assessments will be carried out by our pharmacy provider by 30 October 2013.	 30 September 2013 30 October 2013 30 October 2013

Theme: Effective care and support

Outcome 10: Reviewing and improving the quality and safety of care

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

Inspectors found the audit tools used for some of the audits were poor.

Data gathered in some audits had not been analysed.

For those audits where data had been analysed and recommendations made there was no evidence that the recommendations had been acted upon.

It was not evident if the audits carried out had lead to an improvement in the quality of care provided or to the quality of life of residents living in the centre.

Action required:

Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.

Action required:

Establish and maintain a system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.

Reference:

Health Act, 2007
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response:	
Our quality improvement policy will be reviewed to reflect the schedule of audits being carried out e.g. Infection control, care planning, Infection Control, nursing documentation, medication Management and complaints.	30 November 2013
Audits will include action plans with date action completed, named responsible person for actions and learning from audits, and date of next audit.	30 November 2013
Nursing Documentation is audited using an adapted HSE Minimum Data Set Tool (DML). This tool will be reviewed and amended to be more specific to our requirements.	31 October 2013
A schedule / cycle will be put in place to carry out future Nursing Documentation Audits.	31 October 2013

We will ensure that our audits are comprehensively analysed and all recommendation are implemented which will continue to improve the quality of care and quality of life for our residents.	31 October 2013

Outcome 11: Health and social care needs

The person in charge is failing to comply with a regulatory requirement in the following respect: Resident assessments were not always completed accurately. Death and dying/end of life assessments were not always completed with residents/or their next of kin following their admission to the centre. Care plans were not updated to reflect visiting allied health professionals recommendations for treatment. Care plans were not person-centred. For example, they did not include residents' personal choice regarding where they would like to eat their daily meals or re perference regarding hygiene needs. Care provided was not reflective of that prescribed by nursing staff in the residents care plan. The evaluation of daily care given was not reflective of the care plan or care given.
Action required: Set out each resident's needs in an individual care plan developed and agreed with the resident.
Action required: Keep each resident's care plan under formal review as required by the resident's changing needs or circumstances, and no less frequent than at three-monthly intervals.
Action required: Make each resident's care plan available to each resident.
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 3: Consent Standard 10: Assessment Standard 11: The Resident's Care Plan Standard 17: Autonomy and Independence

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We are reviewing the particular Resident assessments and are ensuring they are completed accurately.	 30 November 2013
End of life care discussions are carried out with residents or their family. Their wishes in relation to their request for care at end of life is discussed in detail.This area of care is very sensitive and not always appropriate on admission.	30 November 2013
Staff will now document that they have attempted to carry out these assessments and family or residents were emotionally unable to take part in the assessment or decision making on admission. It will be reviewed with NOK or resident at the three monthly reviews.	30 November 2013
We will continue ongoing training for staff in End Of Life Care.	30 November 2013
All Allied Professionals were writing up their recommendations in their own clinical notes and sending reports. All allied professional recommendations will now be documented in the nursing care plan and daily evaluation document	30 November 2013
Each residents needs will be set out in a care plan to include their wishes in relation as to where they would prefer to eat their meals.	30 November 2013
Each residents needs will be set out in a care plan to include their wishes in relation to their preference regarding bathing needs	30 November 2013
All care plans are reviewed three monthly or sooner if required in consultation with the resident or their family. Resusitation status will now be reviewed in this consultation process.	
Each residents Care Plan is made available to each resident and will continue to be so.	

Theme: Person-centred care and support

Outcome 13: Complaints procedures

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

A record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied was not available.

It was not evident as records were not in place to determine if all complainants were informed promptly of the outcome of their complaint and details of the appeals process.

Record all complaints and the results of any investigations into the matters complained about were not available for each complaint as evidenced in the report.

The complaints policy did not meet the legislaive requirements as it did not include the name of an independent person who was appointed to oversee complaints. There was no wriiten evidence that this process had been put in place or was practiced in the centre.

Action required:

Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.

Action required:

Inform complainants promptly of the outcome of their complaints and details of the appeals process.

Action required:

Record all complaints and the results of any investigations into the matters complained about. Ensure these records are in addition to and distinct from a resident's individual care plan.

Action required:

Make a person available, independent to the person nominated in Regulation 39(5), to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 39(5) maintains the records specified under Regulation 39(7).

Action required:

Ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.

Reference:

Health Act, 2007
Regulation 39: Complaints Procedures
Standard 6: Complaints

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

Provider's response:	
We are very satisfied with our very low level of complaints. We will amend our Complaints policy and procedure and records to indicate if the complainant is satisfied or unsatisfied with the outcome of the complaint	30 September 2013
This amendment will include complaintants being informed promptly of the outcome of their complaint and details of the appeals process	30 September 2013
The complaints register is maintained distinct from the residents individual care plans	30 September 2013
An independant person reviews complaints register to ensure all complaints are approperiately responded to.	30 September 2013
The Complaints Policy has been reviewed to reflect this. Complaints policy will be reviewed to reflect legislative requirements	
We will continue to ensure that no Resident is adversely affected by reason of the complaint been made	26 August 2013