Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	St. Peter's Nursing Home
Name of provider:	Costern Unlimited Company
Address of centre:	Sea Road, Castlebellingham, Louth
Type of inspection:	Unannounced
Date of inspection:	14 May 2026
Centre ID:	OSV-0000122
Fieldwork ID:	MON-0048597

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

St Peter's is a purpose built nursing home which was extended in recent years. It offers care to 69 residents, male and female over the age of 18 years. The centre provides long-term residential care, convalescent and respite care. They care for those with a diagnosis of dementia and an acquired brain injury. They cater for those of low, medium, high and maximum dependency. Their purpose is to provide care on an individualised, fair and in an equal way while involving the resident and their families. The centre has 63 single and three twin en-suite bedrooms. Included in this is a 20 bedded dementia care unit. The centre is situated within five minute's walk of the village of Castlebellingham where residents' can access a variety of amenities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	66

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 14 May 2026	07:00hrs to 16:30hrs	Sheila McKevitt	Lead

What residents told us and what inspectors observed

This was an unannounced inspection carried out over one day. Overall, residents appeared happy while living in the centre. Residents spoke positively about the staff and how 'kind' they were.

Most of the residents that spoke with the inspector said their call-bells were answered in a timely fashion however, two residents said that sometimes they had to wait for 10 -15 mins for there call-bell to be answered. The inspector observed that some residents did not have their call bell within reach when they were asleep in bed. This meant that they would not be able to call for assistance should they required it, upon waking up.

Residents' bedrooms were observed to be clean and organised. There was adequate space for residents to store clothing and other personal items. Residents whom the inspector spoke with said their bedrooms were 'cleaned daily'. Since the last inspection the provider had refurbished some of the internal areas of the centre. The communal spaces were found to be well-maintained with adequate and appropriate new seating for residents. The new bright furniture was organised in a manner that made these rooms appear more homely and a comfortable area for residents use. The new furniture was positioned in the sitting rooms, dining rooms and there was an enhanced coffee dock area for families to enjoy with residents. Residents spoken with said it was lovely and did make a difference.

Visitors informed the inspectors that they can visit their relatives in either the communal areas or in their bedrooms and that visiting was not restrictive.

Residents provided positive feedback about the laundry service stating that their clothes were returned promptly. The feedback on food and the choice available was mainly positive. The inspector noted that the vegetables available at lunch time were not included on the menu displayed.

There was an activity schedule in place seven days a week with two activity staff now employed. Residents appeared to enjoy their time in activities and praised the art class and the newly refurbished activities room which they now called the cinema room. Some residents were observed in their bedrooms throughout the day. However, these residents assured the inspector that this was their wish and that staff 'respected' this.

The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in place and how these arrangements impact on the quality and safety of the service being delivered.

Capacity and capability

The level of compliance in this centre had deteriorated since the last inspection in June 2025. A new person in charge had been appointed in August 2025 andthe governance and management of the centre had stabilised. However, this inspection found that management oversight of service and staff practices was inadequate, which had the potential to adversely impact the quality and safety of the residents. Significant risks associated with medication management practices had not been identified by providers' own auditing systems. In addition, the registered provider had failed to ensure that all staff working in the centre had the required training and knowledge to support them in the safe delivery of care.

This was an unannounced monitoring inspection. The purpose of the inspection was to assess the provider's level of compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2013 to 2025 (as amended). The inspector also followed up on the compliance plan from the last inspection in June 2025 and on nine pieces of unsolicited information brought to the attention of the Chief Inspector since the last inspection, some of which were partially substantiated.

This centre was part of the Trinity Care Nursing Home Group.The senior management team and clinical governance team met on a regular basis. The provider, two persons participating in management with senior responsibility for the centre, the human resource and finance manager supported the person-in-charge in their role. In addition, there was an assistant director of nursing and two clinical nurse managers supporting the person-in-charge. A new software audit tool had been introduced since the last inspection and although there was oversight of service provided in many areas, it had not identified the gaps in service and areas for improvement as found on this inspection. This is evidenced in the findings outlined under Regulation 23: Governance and management.

The provider had invested in resources including staffing, fixtures and fittings. The new furniture and fittings were having a positive impact on the lives of residents living in the centre. In addition, the additional resources put into the activity staffing level and the environment had enriched the social aspect of the residents' lives.

There was adequate staffing levels to meet the needs of residents. There was a high turnover in staff since the beginning of the year with some vacancies in the process of being filled. Gaps in the rosters were being filled by existing staff doing extra shifts or the employment of agency staff, therefore care delivery was not being negatively impacted due to current vacancies.

Staff working in the centre caring for residents did not all have up-to-date mandatory training in place to enable them to care for residents safely. This did negatively impact the standard of care being provided to some residents as outlined

in this report. This is further discussed under Regulation 16: Training and staff development.

The recruitment records although available for review did not all include the required documents outlined in Schedule 2.

Regulation 15: Staffing

There was a sufficient number of staff rostered on duty to ensure the care needs of the 66 residents were met in a prompt and safe manner on the day of this inspection. The staffing levels were adjusted according to the number and assessed needs of residents on both the main and dementia unit.

There was a minimum of one qualified nurse on duty on each of the two units at all times.

Judgment: Compliant

Regulation 16: Training and staff development

Not all staff had received the mandatory or relevant training to support them in effectively caring for the residents. A review of the staff training records provided to the inspector and identified the following:

- A large cohort of staff had not completed refresher fire training within the required time-frame. For example, 19 staff were due refresher training on 26/02/26 they had not received it to date, however were booked in on the next training scheduled for 10/06/26.
- 7 staff on the roster had not completed any fire training to date. This posed a significant risk that in the event of fire, they would not know how to support the safe evacuation of the residents.
- While just over half of the staff had completed relevant training in human rights-based approach to care, the practices observed on the day showed that further action was required to promote a person-centred culture, as further evidenced under Regulation 9: Residents rights.
- 7% of staff rostered to work in the centre had not completed training on how to safeguard vulnerable residents.
- 60% of staff had completed training to enable them to care for residents with responsive behaviors (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) safely. This was despite the provider providing assurance following the last inspection that all staff would have this training in place by 30th November 2025.

Judgment: Not compliant

Regulation 23: Governance and management

The management systems in place to ensure the service provided was, appropriate and consistently monitored were ineffective in a number of areas and improved oversight in aspects of service are required. For example:

- There was a lack of assurance that staff in key roles understood their roles and responsibilities in safeguarding the residents living in the centre. For example, the night staff nurse was unable to inform the inspector of the correct number of residents in the centre on the morning of inspection. This posed a significant risk to the care and welfare of residents in the event of critical incidents such as fire or missing persons.
- Oversight of staff practices to ensure a human rights-based approach and person-centred culture was provided at all times required to be strengthened. For example, a number of residents did not have call-bell access on the morning of the inspection.
- The registered provider failed to comply with its own policy and minimum regulatory requirements in respect of the provision of staff training. All staff did not have access to appropriate mandatory training in a timely manner to ensure they could care for residents safely in the event of a fire, safeguard residents from abuse or uphold their right to call for assistance when required. A number of staff were working in the centre without fire training or safeguarding vulnerable adults training, which posed a safety risk.
- The registered provider failed to abide by commitments given to the Chief inspector following the last inspection in respect of ensuring that staff were trained in respect of the management of responsive behaviours
- Some of the audits conducted to date in 2026 were not capturing current practices. The medication management audit had not been completed in January 2026 as per the audit schedule for 2026. The medication management audit completed in April was 100% compliant. This did not reflect the medication management practices or facilities observed on this inspection.
- The monthly call-bell audits were not sufficiently robust and did not include a sample large enough to get a thorough picture of practices. For example, there were 66 residents living in the centre and most of these audits consisted of 3 to 5 call-bells being rung within the month. Medication management practices were not reflective of the centre's medication management policies, best practice and therefore were not safe.

Judgment: Not compliant

Judgment: Not compliant

Regulation 34: Complaints procedure

The management of complaints was not sufficiently robust and for those reviewed the following was identified:

- The complaints policy was not fully implemented in practice. For example, there were three complaints which had remained open for greater than 30 days, although they had been investigated and an outcome reached.

Judgment: Substantially compliant

Regulation 21: Records

One of the three staff files reviewed did not contain two references for the employee working in the centre.

Judgment: Substantially compliant

Quality and safety

It was evident that the team of staff in St Peter's nursing home knew the residents well and worked hard to ensure that the basic needs of residents' were met. However, the over all standard of nursing care being delivered required improvement to ensure residents' received a high standard of evidenced-based nursing care, where their rights were upheld and practices were safe at all times.

The inspector reviewed a sample of residents' records and saw that residents were assessed using a variety of validated tools. Care plans were updated within four months, the majority of those care plans reviewed reflected the treatment and interventions required by the resident. However, some care plans were not detailed enough to guide practice. This is outlined further under Regulation 5: Individual assessment and care plan.

The policies for medication management were not followed by all staff in practice. The storage of medications required review to ensure practices did not pose a risk to residents, as outlined under Regulation 29: Medicines and pharmaceutical services.

Residents had access to appropriate medical and social care professionals. Referrals were made to professionals such as General Practitioners (GPs), palliative care, psychiatry, speech and language (SALT), dietitians, and tissue viability nursing (TVN). Residents also had access to the group's physiotherapist and occupational therapist.

Residents had access to local and national newspapers, television and radio, along with access to an independent advocacy service. There was a programme of activity scheduled daily and the inspector observed residents who were active and socially engaged throughout the day of the inspection. However, the inspector also observed some institutionalised practices where residents' rights were not supported, such as some residents not having access to their call-bell, as discussed under Regulation 9: Residents' Rights.

Regulation 17: Premises

The medication room in the main unit was not clean or tidy.

- The floor was visibly unclean.
- Four oxygen cylinders were unsafely stored within this room; they were not secure with one falling to the floor. In addition, there was no sign on the door to alert staff that oxygen was stored within the room.
- The worktop surface was inaccessible to staff, with items stored on the surface including sharp boxes, record files and boxes of food supplements. This meant that staff did not have access to a suitable surface to prepare medications.
- The stainless steel sink was difficult to access as it was positioned in a corner of the room, which was notcto a high standard of infection prevention and control.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The inspector was not assured that all medicinal products were stored securely in the designated centre. For example:

- One medication trolley was left unattended on the corridor with the door of the trolley unlocked. The medications within the trolley were therefore accessible to both residents and staff, posing a safety risk.
- Medications of residents who had died in January and April 2026 remained in the controlled medication cupboard; these medications had not been returned to pharmacy in a timely manner.

The inspector were not assured that the process in place for returning medications to pharmacy was safe. For example:

Action was required to ensure that all medicinal products no longer required by a resident were disposed of in accordance with the centre's own policy. Records showed that no medications had been returned to pharmacy since 19 March 2026. However, there were several medications in the return box that had not been recorded in the returns book.

The administration of controlled medications was unsafe and not in line with policy. The inspector found that the process of two nurses checking and signing for controlled drugs was not implemented in practice. The inspector saw that one nurse had removed, administered and signed for the administration of at least two controlled drugs to residents without checking with a second nurse at any stage. This posed a significant risk to the safety of the residents.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The majority of care plans reviewed were person-centered, some gaps were identified which required action, for example:

- A number of residents nursed on pressure relieving mattresses did not have the details of the type of mattress or the required setting for the mattress entered in their care plan. This was important information to ensure the mattresses were set to match the appropriate weight of the residents so that they were effectively meeting the residents' needs in line with their assessment.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had a medical review completed within a four month time period, or sooner, if required. There was evidence that residents had access to all required allied health professionals services and inspectors saw evidence that a variety of these practitioners were involved in caring for the residents.

Judgment: Compliant

Regulation 9: Residents' rights

While residents had their social and religious needs met, a rights based approach to care was not being delivered by staff as reflected from the following findings:

- Multiple residents had no access to their call-bell at 7am, which meant that they would not be able to call for assistance should they require

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 21: Records	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St. Peter's Nursing Home OSV-0000122

Inspection ID: MON-0048597

Date of inspection: 14/05/2026

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • A full review of the training matrix has been carried out and will be reviewed monthly or more frequently if required to ensure compliance. • The 19 staff due for refresher Fire Safety training have completed the training on 12th June 2026. • The 7 staff who have yet to complete fire safety training have completed it on 12th June. • All staff, during induction given guidance on how to manage in the event of fire, same recorded. Fire drills take place monthly and staff participate at the time. • All staff in the building have completed human rights-based training. • Safeguarding training for the 7% of staff attended the training on 17th of June. • 16 staff attended Responsive behavior training in August 2025 following the inspection. A further 18 staff who's training fell due attended behavior training in March and April 2026. The 3 staff who are overdue for the training and 14 recently hired staff are due to attend training on 25th of June.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The nurse on duty in the main building is responsible for the nursing home at nighttime. This is highlighted on the roster. • The PIC has met with staff and has reiterated everyone's responsibility to the residents including safeguarding of the residents. In addition the handover now contains the	

number of residents in the home and the number of residents in hospital. A Notice board is now in place with total number of residents in the home, number of residents outside the home. This board also includes names of the staff appointed as Fire Marshall, IPC nurse, Complaint officer.
• PIC and ADON attend daily handovers to ensure communication is maintained.
• Staff have been instructed to identify the location of the nurse call bell on EPIC when they have completed care for a resident
• Refresher fire training for the 19 staff was completed on 12th June
• The 7 staff who had not completed the fire safety training completed it on 12th June. Staff were be supported by a senior HCA while on duty until training is completed.
• Safeguarding training for the 7% of staff was completed on 17th June.
• Total of 16 staff attended Responsive behavior training in August 2025 following the last inspection. A further 18 staff who's training fell due attended behavior training in March and April 2026. The 3 staff who are overdue for the training and 14 recently hired staff are due to attend training on 25th of June.
• A full external medication audit has been carried out and areas identified for improvement will be actioned.
• Call Bell audit will be reviewed to contain 10% of the residents within the home.
• The center plans to update the call bell system which will give a better oversight of response time, in addition residents will be asked if they are satisfied with the response after they activate the call bell.
• The PIC will monitor all audits monthly to ensure completion, reflecting the practice and action plan in place and completed.
• All staff requested to read medication policy and will be reviewed by the PIC.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• PIC will monitor Complaints and will make sure policy is followed up.
• The 3 complaints open at the time of the inspection which had not been completed, awaiting satisfaction from the complainants have been closed as recommended by the inspector and have since been reopened as responses from the complainants have been received.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• All Staff HR files have been reviewed, to ensure required documentation is on file. The HR file missing a reference has now been received.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Medication room has been deep-cleaned and is now in the cleaning schedule.
• PIC, ADON will review medication room during daily quality walk around.
• Oxygen cylinders are now stored safely in the medication room on a designated trolley and secured. Signage of oxygen storage is displayed on the door.
• The worktop surface has been cleared to ensure suitable access for the medication preparation.
• The positioning and type of sink will be reviewed with a view to relocating it.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
administration of medication. As part of the education PIC has highlighted medication to be kept safe, medication trolley is to be kept locked and secured when not in use and monitored by PIC in a daily basis.
• Medications of the residents who passed away were returned to pharmacy.
• Medications no longer required have been returned to pharmacy and documented
• All nurses have been requested to complete the online HSE land medication administration training.
• Nurses have been reminded of the obligation to be aware of ABA medication management specifically regarding MDMA medication and checking and administration required by 2 people.
• Nurse involved in the controlled drug medication error was provided with a further three days induction, supervised medication management was also included as part of this.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
• Full review of residents using air mattress has been conducted. All care plans have been updated so that pressure-relieving mattresses are:
• Clearly identified by type
• Set correctly in line with each resident's assessed needs.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• PIC and ADON conducted an immediate check of all residents' call-bell accessibility, especially first thing in the morning.
• Reviewed morning routines and discussed with staff to ensure call-bells are not removed during personal care and forgotten to be returned.
• The call bell audit will be reviewed to contain 10% of the residents within the home.
• Additional checks of the call bells being within reach will be documented in epic.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30/08/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/07/2026
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	31/07/2026
Regulation 23(1)(d)	The registered provider shall ensure that management	Not Compliant	Orange	30/06/2026

	systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Not Compliant	Orange	30/06/2026
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Orange	30/06/2026
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal	Not Compliant	Orange	30/06/2026

	products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.			
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Substantially Compliant	Yellow	30/06/2026
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	30/06/2026
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise	Not Compliant	Orange	30/06/2026

	choice in so far as such exercise does not interfere with the rights of other residents.			