Skibbereen Residential Care Centre  
Baltimore Road,  
Skibbereen,  
Co. Cork.

Date: 18th December, 2006.

Inspection Report

Re: Inspection of Skibbereen Residential Care Centre under the Health (Nursing Homes) Act, 1990 and the Nursing Homes (Care and Welfare) Regulations, 1993.

Dear Sir/Madam,

The Health Service Executive Nursing Home Inspection Team inspected Skibbereen Residential Care Centre, Baltimore Road, Skibbereen, Co. Cork from 6.00 p.m. to 11.00 p.m. on 27/11/2006 and from 9.30 a.m. to 2.30 p.m. on 29/11/2006. This inspection was unannounced.

There were 41 residents on this date. The Nursing Home is currently fully registered for 50 residents.

The following issues require your attention and action.

Article 5. The Registered proprietor and the person in charge shall ensure that there is provided for the dependant persons maintained in a nursing home

Article 5a: Suitable and sufficient care to maintain the persons welfare and well-being, having regard to the nature and extent of the persons dependency;

Breach:
The resident in room 3 was found lying in a soiled incontinence pad which had saturated his underwear and the flat sheet of his bed. This man has a pressure sore on his left buttock, 1 cm in size, which was in direct contact with urine and faeces. Vaseline was the only treatment being administered to the wound. This man is of maximum dependency and was admitted to this nursing home in July 2006 with his skin integrity intact. There was no documentation evident in relation to his toileting or skin care regime while the nurse on duty stated that he had recently been attended to.

Required Action:
Training and education for nursing staff and care attendants needs to be addressed in relation to:

Scope of practice and delegation of roles

Documentation

Assessment and management of wounds

Assessment, prevention and management of pressure sores
Continence Assessment and management of incontinence

Evidence based practice

**Timescale:**
To be commenced within 3 months from time of report.

**Article 5.b. A high standard of nursing care.**

**Breach:**
A high standard of nursing care was not met as there was no documentation evident referring to:

Room 9 - It was noticed that there were two bruises, one on each of the anterior aspect of this lady’s right and left legs just above the level of her ankle, the size of each bruise 4 cm by 4 cm, the colour black and blue. There was no explanation from the nurse on duty in relation as to how the bruises were sustained.

**Required action:**
Training and education of the nursing staff and care attendants needs to be addressed in relation to:

Documentation

Scope of practice

**Timescale:**
Training and education to be commenced within 3 months from time of report.

**Article 10.5.d** The registered proprietor and the person in charge of the nursing home shall ensure that a sufficient number of competent staff are on duty at all times having regard to the number of persons maintained therein and the nature and extent of their dependency.

**Breach:**
The number of nurses on duty from 8 a.m. to 2 p.m. is not sufficient having regard for the number of persons maintained therein and the nature and extent of their dependency.

**Required action:**
Extra Registered General Nurses should be employed and in position for the 8 a.m to 2 p.m. shift daily.

To promote competencies nursing staff and care attendants must be educated and trained in issues relating to scope of practice and how competencies are achieved.

Delegating appropriate roles to the appropriate staff must be reviewed.

Competent staff should be familiar with up to date evidence based practice.

**Timescale:**
Extra RGN’s should be recruited within 4 weeks from the time of the report. Development of competencies should be commenced within 3 months from the time of report.
Article 12(a). The registered proprietor and the person in charge of the nursing home shall:-a) take precautions against the risk of accidents to any dependant person in the nursing home and in the grounds of the nursing home.

Breaches:
Cleaning chemicals: A number of cleaning chemicals were found to be very easily accessible to residents and may present risk of an accident. These included “Miltons” on the wash hand basin in room 5; Sanitisers in sluice room 1 (unlocked); Bottles of “CIF” cleaners stored within easy reach on shelving in Bathroom 2; Brasso and “CIF” stored on the wash hand basin in the women’s toilet.

The cleaning room in the home was relocated to a smaller room last year and can now only accommodate equipment and chemicals for use in connection with the kitchen. There is no other lockable dedicated store or cleaning room for the storage of cleaning chemicals.

Electrical faults:
The following electrical faults were found at the time of inspection:

Room 5 the overbed light switch was cracked in three places (this was disabled at the time of inspection);

There was a bulb missing from the overbed light in room 9 (this was replaced at the time of inspection).

The ends were missing from the white pvc trunking covering electrical cabling in rooms 7 and 14. This gives access to the back of the electrical switches.

Storage of equipment:
Wheelchairs were being stored in common corridors; floor cleaning machines were stored in the hairdresser’s room and a hoover was stored in the women’s toilets. These could present tripping hazards.

Required action:
Store cleaning chemicals so that residents cannot access them e.g. in a locked cupboard or room. (Also see note under article 14.b with regard to the provision of a cleaning room).

Replace the light switch and the ends to the pvc trunking.

Ensure that equipment is not stored in any common areas or rooms.

Timescale:
Immediately.

Article 14 (a) The registered proprietor and the person in charge of the nursing home shall: a) ensure that the nursing home and its curtilage is maintained in a proper state of repair and in a clean and hygienic condition.

Breaches:
The carpet in the day room was stained with dried on liquids in parts and the carpet in room 29 was stained.
There was dust to the top of mirrors and cabinets in the majority of rooms showing a lack of regular cleaning to these areas.

There was masking tape to toilet bowl in room 39, this area could not be easily cleaned.

There was a tile missing from the wall surface in bathroom 2 and other tiles were cracked. This can make the cleaning of these surfaces difficult.

**Required action:**
You informed us that the carpet in the day room is to be removed and replaced with more suitable flooring. Until this is carried out it should be thoroughly and effectively cleaned as far as is possible.

Thoroughly and effectively clean the carpet in room 29 or where this is not possible, then provide a more suitable floor covering e.g. one that is capable of being easily cleaned. Provide this office with product details on the type of flooring in use together with cleaning instructions.

Ensure that the high level surfaces in each room are thoroughly cleaned and are included on the cleaning schedule and cleaning checklist so that they are not missed in the future.

Replace the missing and cracked tiles in the bathroom.

**Timescale:**
Cleaning to be carried out immediately.

Tiling to be carried out in the next four weeks.

**Article 14.b.** the registered proprietor and the person in charge of the nursing home shall make adequate arrangements for the prevention of infection, infestation, toxic conditions or spread of infection and infestation at the nursing home”.

**Breaches:**

**Laundry:**
There is no wash hand basin available in the laundry. This presents a risk of infection to the worker handling any soiled clothing or linen.

**Cleaning room:**
The existing cleaning room is too small and is currently used for storing cleaning chemicals and equipment for the kitchen and food preparation areas. There is no other cleaning room and the current practice is that cleaning buckets are filled at the sinks in the sluice room. This gives a potential for contamination of clean equipment e.g. buckets; cloths and mops and this could give rise to possible spread of infection.

**WC2:**
There was no hand towel dispenser or any hand towels provided to the WC 2.

**Required action:**
Provide a lockable separate cleaning room with a low level sink and hot and cold water supply. Ensure there is space for cleaning chemicals to be stored and facilities to allow mops to be hung up after use.

Provide disposable hand towels immediately to wc2.
Timescale:
Four weeks.

**Article 14.c** ensure that there are adequate arrangements for the laundering at regular intervals, and as the occasion may require of linen, clothing and other articles belonging or used by dependent persons maintained at the home.

**Breach:**
The current laundry is too small in relation to the size of the home. The majority of space is taken up by the washer dryers leaving little room for the ironing, pressing and sorting of garments.

**Required action:**
We were informed that there are plans to extend the size of this room within the next two years. In the meantime should the laundry come under any more pressure you should provide additional arrangements e.g. source out the laundry to an outside company or convert one of the empty purpose built houses in the grounds.

**Timescale:**
As outlined above.

**Article 19.1.g.** States that a record of any accident or fall involving a dependant person should be made and maintained in a safe place.

**Breach:**
There was no record of any accident or fall to account for the bruises on the legs of the resident of room 9.

**Required action:**
Training and education of nursing staff and care attendants in relation to recording and documenting any accidents or falls.

**Timescale:**
Training and education to be commenced within 3 months from time of report.

**Article 19.1.h.** States that a record of any occasion on which physical or chemical restraint is used, the nature of the restraint and its duration should be documented and maintained in a safe place.

**Breach:**
The lady in room 9 had cotsides up at the side of her bed but no written documentation or consent was evident in relation to the use of these restraints.

**Required action:**
Training and education of nursing staff and care attendants in relation to recording and gaining consent for the use of any physical or chemical restraint.

**Timescale:**
Training and education to be commenced within 3 months from time of report.
**Recommendations:**

Designate one room for the storage of your equipment. This will also facilitate the checking and maintenance of your equipment.

Extra time should be devoted to cleaning by increasing the hours of the additional cleaner. Extra information should be included on the cleaning schedule so that it is clear as to what the cleaning method in each area consists of and which chemicals are to be used. The cleaning checklist should be revised to ensure all areas are covered.

The Chairperson of the Inspection Teams to be notified in writing on or before the above dates the steps taken by the nursing home to carry out the actions as required under the regulations.

Signed:

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Chairperson                      Inspection Team Member                      Inspection Team Member

cc. Person-in-Charge of Nursing Home

Name: