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The Rock Nursing Unit inspection report, 16 May 2013

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**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	The Rock Nursing Unit
Centre ID:	0623
Centre address:	Ballyshannon Co Donegal
Telephone number:	071-9851303
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Type of centre:	<input type="checkbox"/> Private <input type="checkbox"/> Voluntary <input checked="" type="checkbox"/> Public
Registered provider:	Health Service Executive
Person authorised to act on behalf of the provider:	Kieran Doherty
Person in charge:	Melissa Currid
Date of inspection:	16 May 2013
Time inspection took place:	Start: 09:30 hrs Completion: 17:30 hrs
Lead inspector:	P.J Wynne
Support inspector(s):	N/A
Type of inspection	<input type="checkbox"/> announced <input checked="" type="checkbox"/> unannounced
Number of residents on the date of inspection:	21 + 1 in hospital
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 11 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 1: Statement of Purpose	<input checked="" type="checkbox"/>
Outcome 2: Contract for the Provision of Services	<input type="checkbox"/>
Outcome 3: Suitable Person in Charge	<input checked="" type="checkbox"/>
Outcome 4: Records and documentation to be kept at a designated centres	<input type="checkbox"/>
Outcome 5: Absence of the person in charge	<input type="checkbox"/>
Outcome 6: Safeguarding and Safety	<input checked="" type="checkbox"/>
Outcome 7: Health and Safety and Risk Management	<input checked="" type="checkbox"/>
Outcome 8: Medication Management	<input checked="" type="checkbox"/>
Outcome 9: Notification of Incidents	<input checked="" type="checkbox"/>
Outcome 10: Reviewing and improving the quality and safety of care	<input type="checkbox"/>
Outcome 11: Health and Social Care Needs	<input checked="" type="checkbox"/>
Outcome 12: Safe and Suitable Premises	<input checked="" type="checkbox"/>
Outcome 13: Complaints procedures	<input type="checkbox"/>
Outcome 14: End of Life Care	<input type="checkbox"/>
Outcome 15: Food and Nutrition	<input checked="" type="checkbox"/>
Outcome 16: Residents' Rights, Dignity and Consultation	<input type="checkbox"/>
Outcome 17: Residents' clothing and personal property and possessions	<input type="checkbox"/>
Outcome 18: Suitable Staffing	<input checked="" type="checkbox"/>

This report set out the findings of an unannounced monitoring inspection. This inspection took place over one day and was the fourth inspection carried out by the Health Information and Quality Authority's (the Authority) Regulation Directorate. The findings of previous inspections concluded that improvements were required to meet all of the requirements in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). These inspection reports can be found at www.hiqa.ie.

There were seven actions plans outlined in the report from the last inspection. These were reviewed during this inspection. The inspector found that all actions except one had been completed satisfactorily. This action related to the requirement to obtain all the information required by Schedule 2 of the Regulations. The previous inspection in the centre was a registration inspection in June 2011. An action plan detailing four sets of actions which required attention was issued to the provider. These mainly involved environmental improvements to the physical aspect of the building. The provider submitted an action plan agreed with the inspector to address the matters identified in the report.

Overall, the inspector was satisfied the centre was operating in compliance with the conditions of registration and found evidence of positive outcomes for residents. Residents spoken with expressed satisfaction with the care provided. The building was visually clean and comfortably warm.

Residents were seen routinely by their GP and allied health professional services as required. Aspects of medication management were in line with professional guidelines. There was a structured program of activities in place facilitated by an activity coordinator. There was an adequate number of nursing, care assistants, catering and cleaning staff rostered on the day of inspection to meet the assessed care needs of residents.

The inspector identified aspects of the service that needed improvement. Refresher training in adult protection was required for some staff. Aspects of care planning required improvement. There was limited evidence of residents or their representative being consulted or agreeing to their care plan when reviewed and updated. The provider is required to have in place a plan to provide suitable accommodation for residents in accordance with the *National Quality Standards for Residential Care settings for Older People in Ireland* within the time frame allowed.

The Action Plan at the end of this report identifies mandatory improvements required to come into compliance with the Regulations.

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

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspector was satisfied that the statement of purpose accurately described the aims, objectives and ethos of the centre and the service that was provided. The statement of purpose set out the services and facilities provided in the designated centre and contained all the requirements of Schedule 1 of the Regulations. The statement of purpose is kept under review by the provider and had been updated in January 2013.

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

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The person in charge has not changed since the last inspection. She is a registered nurse and holds a full-time post. She was well known by residents. She had good knowledge of residents care needs and could describe in an informed way where residents had specific needs and how staff ensured that their care needs were met appropriately. This was observed during the inspection.

The person in charge maintained her professional development and attended mandatory training required by the regulation in fire evacuation, safe moving and handling of residents and adult protection. In addition the person in charge was presently undertaking a post graduate diploma in nursing science and had completed modules on:

- clinical audit
- wound management and tissue evaluation
- quality and healthcare management
- dementia care and communicating with older people.

There was an organisational structure in place to support the person in charge. There are two clinical nurse managers to deputise in the absence of the person in charge. The arrangements and reporting systems were known to staff and were described in the statement of purpose.

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.*

Records in relation to residents (Schedule 3)

Substantial compliance

Improvements required *

It was identified on the last inspection accident and incident reports were not completed in full and the time of a fall and whether it was witnessed was not always

recorded in all cases. In the sample of report forms viewed all aspects of the record were fully completed and information recorded included factual details of the accident/incident, date and time event occurred, name and contact details of any witnesses and whether the GP and next of kin had been contacted. An audit process was introduced since the last inspection to monitor incident forms to ensure they are completed accurately.

Operating Policies and Procedures (Schedule 5)

Substantial compliance

Improvements required *

A selection of operating policies that inform the centres practices were reviewed. The policy on risk management required further review and is discussed in more detail under Outcome 7.

Staffing Records

Substantial compliance

Improvements required *

The improvements related to staffing records are discussed in more detail under Outcome 18.

Medical Records

Substantial compliance

Improvements required *

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

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Residents spoken with stated that they felt safe in the centre. There was a visitors log in place and entrance to the centre was restricted to ensure residents safety. Entrance and exit doors were monitored by CCTV. No incidents, allegations or suspicions of abuse have been recorded or notified to the Authority in the preceding 12 months at this centre.

Staff spoken with were able to inform the inspector of what constituted abuse and of their duty to report any suspected or alleged instances of abuse. Staff identified a senior manager as the person to whom they would report a suspected concern. However, eight staff were identified as requiring refresher training in adult protection as the time period since their last training had exceeded the HSE two-year time frame in line with the HSE policy on adult protection.

The inspector was provided with a copy of the centre's policy on prevention, detection and response to elder abuse. The policy defined the various types and signs of abuse and the reporting arrangements. The policy outlined clear procedures to investigate any allegation of suspected or confirmed abuse. The policy contained the contact details of the HSE elder abuse case worker and a referral form to report matters should they arise.

Garda Síochána vetting was available all staff members. This was evidenced by a review of returned Garda Síochána vetting forms examined by the inspector in staff files. No new staff were recruited since the last inspection.

The financial controls in place to ensure the safeguarding of residents' finances were not examined by the inspector during this visit.

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

Actions required from previous inspection:

Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

Inspection findings

This action was completed. All wash-hand basins in resident's bedrooms are fitted with thermostatically controlled valves. A system is in place and was reviewed by the inspector indicating all thermostats are checked monthly and temperatures recorded. Hand testing indicated the temperature of dispensing hot water did not pose a risk of burns or scalds.

The risk management policy was revised in December 2012. The governance arrangements to manage risk situations were specified. Responsibility for health and safety procedures and an organisational safety structure was included in the policy.

Risk assessments included an environmental and clinical identification and assessment of hazards throughout the centre. Controls were specified and rated to minimise risks. A risk register was maintained by the person in charge. Hazards identified on the risk register were escalated to the provider if the person in charge was unable to resolve them.

A maintenance log was maintained to report any faults noted on a day-to-day basis such as call bells, lighting or problems with residents furniture and were promptly attended to by a maintenance person. There was a health and safety committee in place with staff represented from each grade and area of work. Regular meetings took place and the minutes were reviewed by the inspector. However, risk assessments to identify potential hazards with precautions to control or minimise risk were not specified for the care environment, communal areas, bathrooms, dining and day sitting room. Due to the design of the physical building the inspector noted the following risks which may pose a hazard to resident:

- access to an unprotected stairway
- limited storage space for equipment. For example, hoists were stored in one multiple-occupancy bedroom and on a corridor outside bathrooms in another area creating a possible trip hazard
- access to a shower area was restricted as equipment utilised by residents was stored in this area

There was a missing person policy in place which included clear procedures to guide staff should a resident be reported as missing. There was an emergency plan outlining contingency arrangements for a variety of situation. Contact numbers for a range of personnel were included. There was a generator on site in the event of power failure which was tested routinely.

There was a risk management policy in place containing procedures to guide staff actions in the event of violence and aggression with further procedures outlined in the policy on challenging behaviour. However, there was not a specific policy with procedures to guide staff actions in the event of self harm. There was policy on accident/incident recording in place. The person in charge said that learning from incidents to minimise the possibility of a similar accident reoccurring was discussed at handover meetings and staff team meetings. However, the risk management policy required further review to outline the arrangements to ensure learning for all staff to minimise the risk of repeat occurrence of similar accidents.

The inspector reviewed the fire register. Records showed that the fire alarm system and the emergency lighting was serviced routinely and fire fighting equipment annually. The fire alarm was tested weekly and automatic door closer regularly checked. However, there was no evidence of routine checks to ensure fire exits were unobstructed and all portable fire equipment was in place and intact.

The inspector read the training records which confirmed that all staff had attended fire training annually. This was evidence by a review of certificates of fire safety attendance. All staff spoken with were very clear about the procedure to follow in the event of a fire. Fire evacuation sheets were fitted to the beds of all residents. However, not all staff had participated in fire drill practices within the past 12 months to ensure they are aware of the procedures to follow to include simulated evacuation and safe placement of all persons in the event of fire.

The inspector viewed evidence staff were trained in the safe moving and handling of residents. A moving and handling assessment was available for each resident in case files reviewed. The inspectors observed safe moving and handling practices during the course of the inspection.

There were arrangements in place for recording and investigating untoward incidents and accidents. All incident and near miss events were recorded which were reviewed by the person in charge. Information recorded included factual details of the accident/incident, date and time event occurred, name and contact details of any witnesses and whether the GP and next of kin had been contacted. The inspector noted that falls and near misses were well described and that neurological observations and vital signs were checked and recorded. Post falls care plan were in place for residents who sustained a fall and were kept under review in the sample examined. However, neurological observations were not recorded in all cases where a resident sustained a fall un-witnessed to determine if a head injury had been sustained and/or the level of consciousness affected.

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

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

There was a comprehensive medication management policy in place which provided guidance to staff to manage aspects of medication from ordering, prescribing, storing and administration.

The inspector reviewed a sample of drugs charts. Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. The prescription sheets reviewed were clear and legible. Regular and PRN (as required) were identified separately. The maximum amount for PRN medication was indicated on all prescription sheets viewed by the inspector.

The medication administration sheets viewed were signed by the nurse following administration of medication to the resident and recorded the name of the drug and time of administration. The drugs were administered within the prescribed timeframes. There was space to record when a medication was refused on the administration sheet.

Medicines were being stored safely and securely in the clinic room which was secured with a coded keypad. The temperature ranges of the medicine refrigerator was being appropriately monitored and recorded.

Medications that required strict control measures were kept in a secure cabinet which was double locked in keeping with the Misuse of Drugs (Safe Custody) Regulations. Nurses kept a register of controlled drugs. Two nurses signed and dated the register and the stock balance was checked and signed by two nurses at the change of each shift.

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

Actions required from previous inspection:

Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any allegation, suspected or confirmed abuse of any resident.

Inspection findings

The inspector examined the accident and incident log which showed that the person in charge had recorded any untoward events and accidents or near misses. The records detailed the remedial action taken. The inspector found that all notifications were notified to the Chief Inspector within the defined timeframe.

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 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

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The centre can accommodate a maximum of 22 residents who need long-term care. There were 13 residents with maximum care needs. Four residents were assessed as highly dependent. Many residents were noted to have a range of healthcare issues and the majority had more than one medical condition.

The arrangements to meet residents' assessed needs were set out in individual care plans. The centre used an electronic record management system and in conjunction with a registered nurse, the inspector reviewed a sample of two care plans in detail and certain aspects within other plans of care. Recognised assessment tools were used to evaluate residents' progress and to assess levels of risk for deterioration, for

example, vulnerability to falls, dependency levels, nutritional care, the risk of developing pressure sores and moving and handling assessments. There was a record of the resident's health condition and treatment given completed daily.

However, risk assessments were not always regularly revised to inform care planning. It was noted one resident did not have a moving and handling assessment completed in a timely manner following admission. There was poor linkage between the assessments and the care plans in some instances. Assessments were not effectively utilised in the implementation and planning of care. While care plans were regularly reviewed there were not regular reviews of evidence-based assessments.

While the inspector viewed some care plans that were person-centred, detailed and took account of resident's wishes as well as their healthcare status, this was not uniformly the case in all care plans examined. One care plan for a resident receiving palliative care was generic and did not outline specific interventions. Another resident while reviewed by the community psychiatric nurse and a treatment plan was outlined in the medical file there was no plan of care to guide staff action for the particular problem of mood disorder.

Staff demonstrated good knowledge and understanding of each resident's background in conversation with the inspector. An assessment of social needs was being completed for all residents which outlined resident's likes, dislikes, past life history, hobbies and preferences. Although there was evidence of consultation with residents or their representative on the assessments for the use of bedrails, there was not evidence in all care plans reviewed of consultation with residents or their next of kin in discussing, understanding and agreeing to their care plan when reviewed or updated.

Residents had access to GP services and there was evidence of medical reviews on at least a three-monthly basis and more frequently when required. A review of residents' medical notes showed that GP's visited the centre regularly. The GP's reviewed and re-issued each resident's prescriptions every three months. This was evidenced on reviewing medical files and drug cards. There was evidence of referral to allied services such as speech and language, physiotherapy and occupational therapy. Records indicated residents received the flu vaccine. A chiropodist attended the centre routinely.

The local palliative care team provided support and advice. The person in charge confirmed the palliative care team will attend the centre outside of core hours if required. This was evidenced by a review of the medical notes where instruction was provided for staff by the palliative team. Where residents had specialist care needs such as mental health problems there was evidence in care plans of good links with community mental health services. A member of the psychiatric team visits the centre to review the resident and their medication to ensure optimum health. Notes confirmed treatment plans were outlined and reviewed as required.

There was one resident with a pressure wound which was notified to the Authority as required by the Regulations. The inspector reviewed this care plan. There was a wound care plan to guide staff on the provision of pain relief, dressings and movement. There was an assessment completed for the wound and there were

visual aids available to monitor progress to determine the effectiveness of treatment being provided. Advice in relation to the type of dressing to apply to the wound and frequency of changing was being adhered to by nursing staff. The person in charge confirmed access to tissue viability was available.

The policy on restraint was based on the national policy on promoting a restraint free environment. The inspector reviewed a sample of assessments that underpinned restraint practice. Restraint measures in place included the use of bedrails by five residents. There were no lap belts in use. There was a risk assessment completed prior to the use of the restraint and assessments were regularly revised. Signed consent was obtained by the resident or their representative. A restraint register was maintained to record the times the restraint measure was applied and released. All residents with a restraint measure were checked at half hourly intervals. Alternatives were considered prior to the use of restraints such as bedrails. Five residents were provided with ultra low beds. All bedrails were integrated into the bed with the exception of one bed where the bedrail was independently attached to the bed. The resident was offered the choice of new bed which was declined by the resident. Weekly checks were undertaken to ensure the rails on this bed were correctly positioned and secure on the bed.

There were opportunities for all residents to participate in activities. There was a structured program of activities in place which was facilitated by the activities coordinator, employed five days each week. The inspector spoke with the activity coordinator who confirmed she had completed training in Sonas. Activities forming part of the weekly program included storytelling, newspaper review and hand massage to ensure meaningful engagement for residents. The activity schedule provided for both cognitive and physical stimulation. There was a live music session each week. Residents were facilitated to practice their religious belief. Mass was took place weekly and an oratory was available for use by residents.

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

Actions required from previous inspection:

Provide heating suitable for residents in all parts of the designated centre which are used by residents.

Provide sufficient numbers of wash-hand basins which incorporates thermostatic control valves or other suitable anti-scalding protection, at appropriate places in the premises.

Provide residents with privacy to the extent that each resident is able to undertake personal activities in private.

Inspection findings

The heating system was replaced and new storage heaters are now in place in all areas. The building was noted to be comfortably warm. Floor covering in kitchen had been replaced and repairs were completed to floor at the bottom of stairs. Wash-hand basins have been installed in bedrooms where required and hand testing indicated the temperature of the dispensing hot water did not pose a risk of scalds. Doors were installed between all bedrooms to ensure privacy for residents to replace previous curtains.

The centre is a historic building originally built in the 1800s. It was established as a community nursing home 1974 and accommodates 22 residents requiring continuing care. All bedrooms and the communal care environment are located on the ground floor consisting of a sitting room and dining room and a conservatory to the front of the centre. Bedroom accommodation comprises five single rooms, five three-bedded rooms and one two-bedded room. There are five assisted bathrooms and eight toilets available. Other facilities included a nurses' office, sluice rooms and a laundry. The first floor is accessed by a lift and a staff changing area, a staff dining room and administration offices are located on this floor.

The multiple-occupancy bedrooms accommodating three residents each varied in size and bed layout configuration. The furniture provided to residents was new. All residents had modern beds, new wardrobes and a locker which allowed them secure personal items. In some bedrooms accessibility to use a hoist by some beds was limited. Bedrooms were not en suite and there were limitations in the ability to maintain residents' privacy while care was in progress at busy period during the morning time. The physical environment posed challenges to meet residents' individual and collective needs and assure their comfort and privacy. Some bedrooms were only accessible by entering through other resident's bedrooms. A number of single bedrooms at one end of the building could only be accessed via a bedroom occupied by three residents. While there were a sufficient number of toilets and bathing facilities, residents in some single bedrooms had to enter another bedroom to gain access to the bathroom. The provider is required to have in place a plan to provide suitable accommodation for residents in accordance with the Regulations and the Authority's Standards within the timeframe allowed.

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 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

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

All residents' weight was monitored on a monthly basis and a nutritional risk assessment was completed. There was specialist equipment available to record the weights of those residents unable to stand on a weigh scales. The inspector viewed residents' weight being monitored and recorded in the sample of care plans reviewed. Those identified at risk of losing weight, had their weight reviewed on a more regular basis. Access to dietetics was provided this was evidenced on reviewing medical files. A nutritional assessment and recommendation was in place in case files examined.

There was a system in place whereby nurses informed the chef about the specific dietary needs of residents. Staff were informed which residents required their meals to be liquidised. A choice was offered at each mealtime and nutritious options were available for the lunch menu. However, the evening meal time menu while offering options required review. The options available did not ensure sufficient or optimum calorific intake particularly those for those on fortified diet. While the person in charge confirmed the menu was reviewed by the dietician, this was not recent and there were no menu choices to ensure optimum calorie intake with appropriate fortified snacks available to include yoghurts, soups and enriched milk as part of the evening meal.

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

Actions required from previous inspection:

Ensure all staff records maintained in the centre contains all relevant information as required under Schedule 2 of the Regulations.

Inspection findings

This action was not completed. A sample of six staff files were examined to assess the documentation available, in respect of persons employed. The staff files were maintained in good order to ensure the required information was easily retrievable for review. However, all the information required by Schedule 2 of the Regulations was not available in the staff files reviewed. While there was photograph of each staff member in files it was not valid photographic identification in the form of a driver's license or passport. Certification by a medical practitioner that staff member was physically and mentally fit for the purpose of the work they perform was not available for each member of staff in files examined.

The provider employs 31 staff in total which includes a whole-time equivalent of 10.5 registered nurses and 15.8 care assistants. In addition, there is catering and an activity coordinator employed. The inspector viewed the staff duty rota for a three week period. The rota showed the staff complement on duty over each 24-hour period. The staff roster detailed their position and name. The inspector noted that the planned staff rota matched the staffing levels on duty. The inspector reviewed staffing rosters and discussed the staffing levels with the person in charge. There was an adequate number of nursing, care assistants, catering and cleaning staff rostered on the day of inspection to meet the assessed care needs of residents. There were three nurses excluding the person in charge and four care assistants rostered from 7.45am to 16.15pm each day of the week and two nurses until 8.15pm.

There was a training matrix available which conveyed that staff had access to ongoing education and the range of professional development training was provided. The inspector found that staff had attended training sessions on infection prevention and hand hygiene, cardio-pulmonary resuscitation techniques, caring for residents with dementia, food hygiene and medication management by six nurses. Staff were trained on best practice in promoting a restraint free environment. A record of An Bord Altranais Professional Identification Numbers (PIN) for all registered nurses was maintained and reviewed by the inspector.

Closing the visit

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

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, person in charge and staff during the inspection.

Report compiled by:

P.J Wynne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

6 June 2013

Action Plan

Provider's response to inspection report *

Centre Name:	The Rock Nursing Unit
Centre ID:	0623
Date of inspection:	16 May 2013
Date of response:	21 June 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: Safe care and support

Outcome 6: Safeguarding and safety

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

Eight staff were identified as requiring refresher training in adult protection.

Action required:

Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Standard 8: Protection
Standard 9: The Resident's Finances

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

Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>All 8 staff identified as requiring refresher training have now received same. The Elder abuse trainer has also attended an updated training day on 14th June 2013 in order to deliver ongoing training within the centre.</p>	<p>21/06/2013 complete</p>

Outcome 7: Health and safety and risk management

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

Risk assessments to identify potential hazards with precautions to control or minimise risk were not specified for the care environment, communal areas, bathrooms, dining and day sitting room. The following risks which may pose a hazard to residents were identified:

- access to an unprotected stairway
- limited storage space for equipment. Hoists were stored in one multiple occupancy bedroom and on a corridor outside bathrooms in another area creating a possible trip hazard
- access to a shower area was restricted as equipment utilised by residents was stored in this area.

Action required:

Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

Reference:

Health Act, 2007
 Regulation 31: Risk Management Procedures
 Standard 26: Health and Safety
 Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>Risk assessments will be completed for all areas throughout the centre. Each room will assessed for risk and these added to the risk register, including the unprotected stairway and storage of equipment. An action plan to control and manage risks will be put in place this will include a checklist.</p>	<p>31/08/2013</p>

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

There was not a specific policy with procedures to guide staff actions in the event of self harm.

The risk management policy required further review to outline the arrangements to ensure learning for all staff to minimise the risk of repeat occurrence of similar accidents.

Action required:

Put in place a comprehensive written risk management policy and implement this throughout the designated centre.

Action required:

Ensure that the risk management policy covers the arrangements for learning from serious or untoward incidents or adverse events involving residents.

Reference:

Health Act, 2007
Regulation 31: Risk Management Procedures
Standard 26: Health and Safety
Standard 29: Management Systems

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

Timescale:

Provider's response:

The local quality safety and risk group reviews all adverse or untoward incidents / events to identify learning. This learning is shared with staff at staff meetings, minutes and also with the wider community hospitals as appropriate to share learning.

The risk management policy will be reviewed to include a protocol to follow in the event of potential or actual self harm. this review will also cover the arrangements for learning from serious or untoward incidents or untoward events.

30.09.2013

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

There was no evidence of routine checks to ensure fire exits were unobstructed and all portable fire equipment was in place and intact.

Not all staff had participated in fire drill practices within the past 12 months to ensure they are aware of the procedures to follow to include simulated evacuation and safe placement of all persons in the event of fire.

Action required:

Make adequate arrangements for reviewing fire precautions

Action required:

Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.

Reference:

Health Act, 2007
 Regulation 32: Fire Precautions and Records
 Standard 26: Health and Safety

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

Timescale:

Provider's response:

A weekly checking system has now been implemented to check that all portable fire equipment is in place and intact. Daily checks have been implemented to ensure that fire exits are unobstructed.
 Monthly fire drills will be completed with staff by the designated fire officer for the unit.

21/06/2013
 complete

ongoing from
 1/07/2013

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

Neurological Assessment were not recorded in all cases where a resident sustained a fall un-witnessed to determine if a head injury had been sustained and/or the level of consciousness affected.

Action required:

Ensure a high standard of evidenced-based nursing practice is met with regard to residents who have sustained a fall.

Reference:

Health Act, 2007
 Regulation 6: General Welfare and Protection
 Regulation 31: Risk Management Procedures
 Standard 8: Protection

Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>A system is now in place that ensures Neurological observations are done in all cases where a resident sustains an un-witnessed fall. All nurses have been informed of this requirement and a copy of the completed neurological observation record is to accompany the clinical incident form when it is sent to the Director of Nursing office for review and sign off.</p>	<p>17/06/2013 complete</p>

Outcome 11: Health and social care needs

<p>The person in charge is failing to comply with a regulatory requirement in the following respect:</p> <p>Risk assessments were not effectively utilised in the implementation and planning of care.</p> <p>Some care plans were person-centred, detailed and took account of resident's wishes as well as their healthcare status, this was not uniformly the case in all care plans examined.</p> <p>There was not evidence in all care plans reviewed of consultation with residents or their next of kin in discussing, understanding and agreeing to their care plan when reviewed or updated.</p>
<p>Action required:</p> <p>Set out each resident's needs in an individual care plan developed and agreed with the resident.</p>
<p>Action required:</p> <p>Keep each resident's care plan under formal review as required by the resident's changing needs or circumstances.</p>
<p>Action required:</p> <p>Revise each resident's care plan, after consultation with him/her.</p>
<p>Reference:</p> <ul style="list-style-type: none"> Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 3: Consent Standard 10: Assessment Standard 11: The Resident's Care Plan

Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>The CNM1 and CNM2 have both attended a care planning workshop along with 3 Nurses. The CNM1 and CNM2 will share learning from this workshop with the remaining nursing staff. Good examples of individualised care planning has been shared with all nurses and resources such as the DML tool have been made available for nursing staff to refer to when writing careplans. Another care planning training event is planned to take place on the 22nd of July 2013 for remaining nursing staff. The CNM1 and CNM2 and the DON will continue to audit and review care plans on a monthly basis to ensure a person centred approach to same is maintained in all cases.</p> <p>All care plans including risk assessments will be kept under formal review at least on a 3 monthly basis or according to each individual residents changing needs and circumstances.</p> <p>All care plans will be revised following consultation and discussion with the resident or their family/carers and this will be documented on each care plan.</p>	<p>31/08/2013</p>

Outcome 12: Safe and suitable premises

<p>The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>The physical environment posed challenges to meet residents' individual and collective needs and assure their comfort and privacy.</p>
<p>Action required:</p> <p>Provide suitable premises for the purpose of achieving the aims and objectives set out in the statement of purpose, and ensure the location of the premises is appropriate to the needs of residents.</p>
<p>Action required:</p> <p>Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.</p>
<p>Action required:</p> <p>Submit a plan as to how the centre plans to come into compliance in terms of deficient's identified relating to physical environment.</p>

Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The long term plan for the Rock Nursing unit is for the unit to be gradually closed. National approval has been sought for the building of 1 purpose built centre in the south Donegal area over the next 3-4 years. This unit will replace the existing Rock nursing unit and Sheil community Hospital in Ballyshannon.	2015

Theme: Person-centred care and support

Outcome 15: Food and nutrition

The person in charge is failing to comply with a regulatory requirement in the following respect: The evening meal time menu options available did not ensure sufficient or optimum calorific intake particularly those for those on fortified diet.	
Action required: Provide each resident with food and drink that takes account of any special dietary requirements and is consistent with each resident's individual needs.	
Reference: Health Act, 2007 Regulation 20: Food and Nutrition Standard 19: Meals and Mealtimes	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Menu options such as yogurt, fortified milk puddings and scrambled eggs are always provided as an option on the evening menu, however this was not communicated to the inspector on the day of the inspection and was not displayed on the menu board. This has now been rectified and all menu choices are being displayed.	28/06/2013

<p>The community dietician visited the centre on the 23rd June 2013 at the request of the Director Of Nursing and carried out a review of the menu provided. Amendments have been made to the menu as a result of this review and a clearer and more specific menu plan is being drafted. A special diet order sheet will be introduced for residents who require fortified diets or otherwise.</p>	<p>01/07/2013</p>
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Theme: Workforce

Outcome 18: Suitable staffing

<p>The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>All the information required by Schedule 2 of the regulations was not available in the staff files reviewed.</p>	
<p>Action required:</p> <p>Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 of the Regulations have been obtained in respect of each person.</p>	
<p>Reference:</p> <p>Health Act, 2007 Regulation 18: Recruitment Standards 22: Recruitment</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>
<p>Provider's response:</p> <p>Valid photographic identification such as drivers licence and passports have been obtained and place in each staff members files.</p>	<p>21/06/2013 complete</p>