	Nursing Home Inspection Report
	Health (Nursing Homes) Act, 1990 and the Nursing Homes (Care and Welfare) Regulations, 1993.
Nursing Home	Hamilton Park
Number of Residents	49
Registered for	87
Nursing Home Address	Balrothery Co. Dublin
Proprietor	Mr. P.J Murphy
Proprietor's Address (if different from above)	As above
Person-in-Charge of Nursing Home	Ms.Deborrah Lynch.
Date and Time of Inspection(s)	03/03/2008 10.30 am to 18.00hrs.
Date report issued	04/04/08
Summary of previous report findings	Following the previous inspection from 09/11/07 the nursing home has not addressed non-compliance under the following regulations. Article 29.1 (a) & (b)
	Current Inspection Summary Findings
Compliance status	Findings of latest unannounced inspection which took place on 03/03/2008 The inspectors findings based on the current nursing home inspectorate regulations are as follows:

Inspection Report

Findings

	Nursing Home Inspection Report	
	Health (Nursing Homes) Act, 1990 and the Nursing Homes (Care and Welfare) Regulations, 1993.	
Summary Findings of Current Nursing Home Inspection	• **Under Care & Staffing the nursing home was compliant with18 out of 21 regulations.** On the basis of this inspection and under current nursing home regulations, there are issues that need to be addressed as outlined below in relation to the Care and Staffing.	**Compliance/Non Compliance**
	• **Under Management the nursing home was compliant with 27 out of 27 regulations.** On the basis of this inspection and under current nursing home regulations, the inspection team would consider the nursing home to have a good standard of management.	
	• **Under Physical Environment the nursing home was compliant with 8 out of 11 regulations.** On the basis of this inspection and under current nursing home regulations, there are issues that need to be addressed as outlined below in relation to the Physical Environment.	
Non-Compliance (This section should be deleted if no non-compliances have been recorded)	**Based on the most recent nursing home inspection the nursing home is non-compliant under one or more regulations. For more details see below.** **Regulation number** — The registered proprietor and the person in charge of the nursing home shall **29 1 (a) &(b)** — *(a) make adequate arrangements for the recording, safe-keeping, administrating and disposal of drugs and medicines;* *(b) ensure that the treatment and medication prescribed by the medical practitioner of a dependant person is correctly administered and recorded.* **19.1 (f)** — *In every nursing home the following particulars shall be kept in a safe place in respect of each dependent person:—* *(f) a record of drugs and medicines administered giving the date of the prescription, dosage, name of the drug*	

	or medicine, method of administration, signed and dated by a medical practitioner and the nurse administering the drugs and medicines;
Non-Compliance	On the day of inspection the Designated Officers reviewed a number of residents prescribed medication and the administration and recording of same. • The Designated Officers noted that resident ** was prescribed a diuretic on 25/01/08 to be administered on alternate days. From 14/02/08 there was no evidence that this medication was administered until 01/03/08 when it was administered daily for three days. When the Designated Officer reviewed the daily administration blister pack containing this resident's daily medication there was no diuretic in the package for any of the remaining days. The Clinical Nurse Manager and the Staff Nurse on duty were unable to locate this resident's prescribed diuretic on the medication trolley. It is unclear from the records as to whether this resident received the diuretic or not. • On the day of inspection the Designated Officer noted that resident ** was prescribed a lipid regulating drug to be administered at night. On review of the daily administration blister pack this drug was packed in the night drugs compartment and was not in the morning compartment for the remaining days. On the Drug Administering Record sheet for this drug it was signed that this lipid regulating drug was administered in the morning and at night for the previous seven days. It is unclear from the records as to whether this resident received the lipid regulating drug once a day as prescribed or twice a day as recorded. • The Designated Officer noted that there was chart on top of the medication fridge in the high dependency unit for checking the fridge temperature for March 2008. There was no fridge temperature recordings recorded on this chart. The fridge contained prescribed enteral feeding, and eye drops for one resident that

	was residing on this unit.
Required Action	*The person in charge to ensure that:* a) Medications are administered in accordance of the "Guidance to Nurses and Midwives on Medication Management" July 2007. b) That there is an accurate record of all prescribed medications administered to all dependant persons in the nursing home. c) Medications received from pharmacy are verified for accuracy. d) The medication fridge temperature is checked and recorded as per Nursing Home Policy. e) A staff medication management education programme is in place. f) Regular audit of medications prescribed/administered.
Timescale	(a) and (b) Immediately as discussed at the feedback meeting on the day of inspection. (c).On delivery of next medications from pharmacy. (d) On receipt of this report. (e) & (f) Within one month on receipt of this report.

Regulation number 19.1 (d)	*In every nursing home the following particulars shall be kept in a safe place in respect of each dependent person:—* *(d) an adequate nursing record of the person's health and condition and treatment given, completed on a daily basis and signed and dated by the nurse on duty.*
Non-Compliance	**Nursing Assessments.** The Designated Officer noted that there were many improvements in the nursing documentation since the previous inspection on 09/11/07. However following a random review of the nursing documentation the following areas for continuous improvement were noted. • The admission assessment form had two separate areas for recording the signatures of the admitting nurse and for the nurse who completes the admission assessment. The

Designated Officers noted that the following resident's admission assessment forms were signed by the nurse for the following residents; **/**/** However there was no signature recorded by the nurse who completed these residents' assessments on admission.

Care Plans.

- On 31/10/07 resident ** was assessed as "*verbally aggressive at times"*, on daily review. The intervention in the care plan stated "spend *time and talk with the resident"* There were no specific interventions documented in the care plan of how the "*verbal aggression*" should be managed. The Designated Officers noted that the Nursing Home had wall posters in place at the nurse's station which outlined specific measures for managing "acute *aggressive outbursts".* This information was not evident in **'s care plan.

- There was a detailed record documented in the daily nursing notes that resident ** had a "*violent/aggressive outburst*" on 25/01/07. On discussion with the Person in Charge who stated that meetings had taken place since this incident and corrective actions taken. However there was no documentation or care plan commenced to indicate how this resident will be managed and monitored.

- Resident ** had a care plan in place for risk of falls. One of the preventative measures documented was "limit *alcohol to two cans of beer"*. This resident also had a care plan in place for risk of seizures. One of the interventions documented in the care plan was *"discourage x from taking too much alcohol"*. There were no specific interventions documented in any of the care plans as to how the resident's alcohol consumption was monitored or managed.

- On review of the nursing documentation resident **'s vital signs were recorded on two different forms. One form had records for 10th /21st & 22nd December 2007, the 2nd form had records for 22nd /23rd & 31st December 2007. This resident had a history of hypertension

and it was documented in the daily nursing notes that this resident complained of chest pain on 02/03/08 and had a blood pressure recorded in the daily progress notes. There was no further evidence of vital signs recorded. There was no care plan in place for this problem.

- Resident ** had vital signs recorded on one form on the 24/01/08 & 02/01/08. On a 2nd form this resident had the vital signs recorded on 24/12/07 & 01/01/08. These records did not provide an accurate assessment as to what frequency these residents required their vital signs to be recorded and documented. 26/10/07 for review on 13/01/08.

Risk Assessment Tools.

- Resident ** had a falls risk assessment in place dated 26/10/07 for review on 13/01/08. There was no signature documented.
- Resident ** had a falls risk assessment completed on 17/01/08; a patient handling risk assessment completed on 19/10/07, and evaluated on 16/01/08. There was no signature documented on these forms.
- Resident ** had a nutritional assessment completed; there was no date or signature on this assessment.

Daily nursing notes.

- Resident **'s daily nursing notes were not reflective of the care plans. The daily nursing notes stated "received *x, all meals and medications taken. He was sleeping the whole day, repositioning done".*
- It was documented in resident **'s daily nursing notes *"received x, wet pad and sheets. Had plenty of oral fluids, care given as plan, needs met"*
- There were similar findings in the following residents daily nursing notes; resident, **/ **/ **/ and **

Required Action

The Person in Charge to ensure that;

a) All nursing assessments are signed dated and timed by the Registered Nurse. (*An Bord Altranais Recording Clinical Practice Guidelines to Nurses and Midwives, 2002).*

	b) Care plans are formulated based on the nursing assessment and are reflective of the holistic needs of the resident. Where possible the resident and or significant other are involved in planning the care. c) An interdisciplinary approach to behavioural management, monitoring and evaluation is reflected in the care plan. d) Clarity is provided for the staff in the use of vital signs forms currently in the nursing home. There is a record documented in the residents care plan specifying the reason the vital signs are recorded and monitored and the frequency and duration of monitoring required. *e)* All risk assessments are signed dated and timed by the Registered Nurse, and have a review date recorded. (*An Bord Altranais Recording Clinical Practice Guidelines to Nurses and Midwives, 2002).* f) The daily nursing record is reflective of the care plans.
Timescale	(a), (b), (e) & (f) On receipt of this report. (c) & (d) Within one week on receipt of this report.

Regulation number **28.1 (b) & (c).**	*In every nursing home there shall be kept in a safe place a record of:—* *(b) all fire alarm tests carried out at the home together with the result of any such test and the action taken to remedy defects;* (c)*.the number, type and maintenance record of fire-fighting equipment.*
Non-Compliance	• On review of the Fire Register the Designated Officer noted that there was no information recorded in the Fire Register to indicate that the Fire Extinguishers or the emergency lighting had been tested. The Person in Charge informed the Designated Officers that the fire extinguishers and the emergency lighting are being tested regularly by a contracted company. The Person in Charge

	agreed that the information required to demonstrate that the fire equipment was being tested was not recorded in the Fire Register.
Required Action	(a) All fire equipment to be checked and documented as outlined in Article 28.1 (b) & (c).
Timescale	(a) Within twenty four hours as discussed at the post inspection feedback session.

Regulation number **14.1 (b)**	*The registered proprietor and the person in charge of the nursing home shall:—* *(b) make adequate arrangements for the prevention of infection, infestation, toxic conditions, or spread of infection and infestation at the nursing home;*
Non-Compliance	a) The Designated Officers noted that residents washbasins were stored on the floor; room **, ** and **. Wash hand basins were also stored on the floor in the sluice room. b) Two boxes of enteral feeding giving sets were stored on the floor of the clinical room. c) The upstairs linen room was also used to store mattresses (on the floor), nebuliser machine and a sealed box containing a new wall mirror.
Required Action	*The Person in Charge to ensure that;* (a) A review of storage facilities is undertaken to ensure that clean and dirty items are stored separately to minimise the risk of infection to the residents. (b) Ensure that items for resident use are not stored on the floor.
Timescale	(a), (b) & (c) Within one week on receipt of this report.

Regulation number **12.1 (a)**	*The registered proprietor and the person in charge of the nursing home shall:—* *(a) take precautions against the risk of accidents to any dependent person in the nursing home and in the*

grounds of the nursing home;

The Designated Officers noted that the nursing home was maintained to a high standard of cleanliness on the day of inspection. However the following issues relating to inappropriate storage of cleaning chemicals were noted by the Designated Officers as a potential risk to the resident's safety.

- The cleaning trolley on the top floor was stored in the general bathroom area, and this trolley contained "*Domestos"* bleach; window cleaner; pink liquid in an unlabelled container; "*Quattro*" cleaner, which had a manufacturers guideline on the bottle which described this product as an "*irritant".* The items on the cleaning trolley were visible and accessible.

- A bottle was left on a ledge on the main corridor next to the linen trolley. It had a hand written label attached to it, which stated "*Disinfectant".*

- On the Nightingale unit there was a bottle left on top of a garbage bin. It had a hand written label attached to it, which stated "*Disinfectant".*

- The upstairs linen room was used to store drip stands which may pose as a safety hazard to any staff member who attempts to take linen from the room.

It is acknowledged that the Nursing Home monitor and audit falls on a regular basis which incorporates preventative interventions that are recorded in the care plans. The Designated Officers observed that all residents were assessed post fall and had vital signs taken and recorded.

- However the Designated Officers noted on reviewing the incidents and accident forms in the nursing home that there was no evidence that the residents who had sustained suspected head trauma at the time of the fall had neurological observations taken post fall. There was no evidence of continued monitoring of vital signs post fall for the following residents; ****/**/**/**/

- It was documented on the incident/accident

forms that the doctor was informed that the following residents had a fall. However the date and time that the doctor was informed was not documented. For example; resident **** had a fall on 17/01/08. It was documented as *"S/B doctor*". There was no date/time documented as to when the resident was reviewed by the doctor. Resident **** had a fall on 19/01/08. It was documented that the resident was reviewed by the doctor or of what intervention was prescribed. There was no date/time documented on the incident form as to when the doctor was informed. There was no outcome of the review documented in the nursing notes.

Required Action *The Person in Charge to ensure that:*

a) The cleaning trolley is stored in a locked room when not in use.
b) When the cleaning trolley is in use the chemicals are stored in a manner to ensure that they are not accessible to any residents.
c) All chemicals are mixed as per manufacturer's guidelines, to include; appropriate labelling to indicate the contents of the solution, the dilution and the date of expiry.
d) Staff access to Safety Data information to ensure that the correct procedure is adhered to in the event of accidental spillage/ingestion of the chemicals.
e) Drip stands are stored in a manner that will not pose as a hazardous to staff/residents.
f) Staff education on points (a) to (d) as outlined above.
g) An interdisciplinary approach to falls management monitoring and evaluation is reflected in the residents care plan.
h) The management and monitoring of residents post fall is researched based and supported with staff educational updates
i) The management and monitoring of residents post fall is documented in the residents care plan.
j) The date and time the doctor is informed is recorded on the incident form.
k) The name of the doctor informed is recorded on the form
l) The outcome of medical review is documented in the nursing notes.

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	m) Regular audit of all accidents and incidents. Timescale: (a), (b) & (e) Immediately as discussed at the post inspection feedback session. (c) & (d) Within two weeks on receipt of this report. (g), (h) & (m) Within one month on receipt of this report. (i), (j), (k) & (l) On receipt of this report.

All regulations, their reference numbers and the details of those regulations can be viewed in Nursing Homes (Care and Welfare) Regulations, 1993.

	Comments and Recommendations
Comments and recommendations made by the inspection team as a result of the inspection	The Designated Officers recommend that all liquid medication has the date of opening recorded to ensure that it can be monitored accurately for expiration date. The Designated Officers recommend that all policies are reviewed and include the following information; • The implementation date. • The next review date. • The name and title and signature of the person responsible for implementing, monitoring and updating the policy to be typed on the policy.
This report has been completed/issued by	________________________ Noel Mulvihill LHO Manager

Recommendations

Author