

	Nursing Home Inspection Report
	Health (Nursing Homes) Act, 1990 and the Nursing Homes (Care and Welfare) Regulations, 1993.
Nursing Home	Santa Sabina House (Dominican Sisters)
Number of Residents	24
Registered for	28
Nursing Home Address	Cabra Dublin 7
Proprietor	Ann M. Killen (Sr Áine)
Proprietor's Address (if different from above)	As Above
Person-in-Charge of Nursing Home	Rosemarie Nolan
Date and Time of Inspection(s)	14.05.08 9.15am – 3.00pm
Date report issued	19 th June 2008
Summary of previous report findings	Following the previous inspection from 20/11/2007, the nursing home has not addressed the non-compliance issue under the following regulations: 19.1(d)
	Current Inspection Summary Findings
Compliance status	Findings of latest (unannounced) inspection which took place on 19/02/2008 The inspectors findings based on the current nursing home inspectorate regulations are as follows:

Inspection Report

Findings

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Health (Nursing Homes) Act, 1990 and the Nursing Homes (Care and Welfare) Regulations, 1993.

Summary Findings of Current Nursing Home Inspection	<ul style="list-style-type: none"> Under Care & Staffing the nursing home was compliant with 17 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.
	<ul style="list-style-type: none"> 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.
	<ul style="list-style-type: none"> Under Physical Environment the nursing home was compliant with 10 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)	<p>Based on the most recent nursing home inspection the nursing home is non-compliant under one or more regulations. For more details see below.</p>	
	<table border="0"> <tr> <td style="vertical-align: top; padding-right: 10px;">Regulation number</td> <td> <p><i>19.1 In every nursing home the following particulars shall be kept in a safe place:-</i></p> <p><i>(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;</i></p> <p><i>29. The registered proprietor and the person in charge of the nursing home shall:-</i></p> <p><i>(a) make adequate arrangements for the recording, safekeeping, administering and disposal of drugs and medicines;</i></p> <p><i>(b) ensure that treatment and medication prescribed by the medical practitioner of a dependent person is correctly administered and recorded;</i></p> <p><i>30. The registered proprietor and the person in charge of the nursing home shall ensure that:-</i></p> <p><i>(a) where medical treatment is recommended and agreed to by a dependent person or the person acting on his or her behalf that it is carried out;</i></p> </td> </tr> </table>	Regulation number
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Compliance/Non Compliance

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Health (Nursing Homes) Act, 1990 and the Nursing Homes (Care and Welfare) Regulations, 1993.

*5. The registered proprietor and the person in charge shall ensure that there is provided for dependent persons maintained in a nursing home:-
(a) suitable and sufficient care to maintain the person's welfare and well-being, having regard to the nature and extent of the person's dependency;*

Non-Compliance

On review of the medication prescribing and administration documentation the Designated Officers noted;

Resident ** was prescribed Difene Gel TDS, this medication was recorded as having been administered at 22.00 only.

Resident ** was prescribed Augmentin TDS on 12/05/08, this medication was recorded on the 13/05/08 as having been administered at 08.00 and 22.00, it was not recorded as having been administered at 14.00.

Resident ** was prescribed Mycostatin on 27/03/08 for 1 week. This medication was not discontinued on the medication kardex by the GP.

Resident ** was prescribed Durogesic patch every 72 hours. This medication was checked and administered as per the MDA ledger however it was not signed for in the medication kardex as having been administered.

Resident ** was prescribed Durogesic patch weekly. This medication was not signed for as having been administered on 05/05/08. On 13/05/08 this medication was checked and administered at 22.00 as per the MDA ledger however it was not signed for in the medication kardex as having been administered.

Resident *** was prescribed Durogesic patch every 72 hours. This medication was not signed for as having been administered on 02/05/08 and 05/05/08. On 13/05/08 this medication was checked and administered at 22.00 as per the MDA ledger however it was not signed for in the medication kardex as having been administered.

Required Action

The Person in Charge to ensure:

1. Ensure that all nursing staff administer medications in accordance with the "Guidance

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- to Nurses and Midwives on Medication Management" July 2007.
2. Medications to be administered as prescribed.
 3. Administered MDA medications to be signed for in the medication Kardex.
 4. Implement the Nursing Home's policy on medication administration.
 5. A full review and audit of all medication prescribed and administration charts to be undertaken.
 6. Review all processes relating to the management of medications within the nursing home to ensure they are functioning correctly.

Timescale

1, 2 and 3 on day of inspection as discussed at the post inspection feedback session.
 4 within 24 hours on receipt of this report
 5 and 6 within 72 hours of receipt of this report.

Regulation number

5. The registered proprietor and the person in charge shall ensure that there is provided for dependent persons maintained in a nursing home:-

(a) suitable and sufficient care to maintain the person's welfare and well-being, having regard to the nature and extent of the person's dependency;

(b) a high standard of nursing care;

19.1 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;

(g) a record of any accident or fall involving a dependent person;

Non-Compliance

The Designated Officers reviewed a random selection of the nursing documentation. Of the files reviewed it was difficult to ascertain what information was reflective of the resident's current health status.

Nursing Assessment

Of the files reviewed the Designated Officers noted that the following resident's assessments were not completed in all sections, **, ** and ***.

Falls Risk Assessment

Resident ** had a falls risk assessment on 03/03/07

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and was documented as low risk however she was being restrained in a buxton chair on the day of inspection, the reason given was to prevent her from falling which conflicts with her assessment. This resident sustained a fall on 07/03/08 however there was no falls risk reassessment undertaken and no revision of her care plan to reflect her altered needs.

Nutritional Assessment

Resident ** had the MUST nutritional assessment undertaken on 19/02/07. The assessment did not have the residents name documented on it. On the assessment form the review date was documented as 3 monthly. There was no documentary evidence to show that this was done. Resident **'s weight was recorded as being **.kgs on 28/07/07, there was no documentary evidence to show that this resident's weight was being monitored on a regular basis. This resident was on a pressure relieving mattress for the prevention of pressure ulcers however the mattress was set to 70kgs and so was placing this resident at further risk of developing pressure ulceration.

Resident ***'s most current nursing assessment was dated 22/07/07 and documented this resident as 'diet normal'. On 23/04/08 this resident was commenced on an intake and output monitoring chart, there was no documentary evidence as to why this monitoring was commenced at this time.

Resident *** was documented in the daily nursing narrative on 08/05/08 as 'taking minimum amount of food', 'very weal and tired', 'just took cup of tea'. There is no documentary evidence that a comprehensive nutritional assessment was undertaken.

Resident *** had two Waterlow assessments undertaken, one entitled 'Waterlow' and one entitled 'Three Monthly Assessment' however they were both the Waterlow assessment being completed simultaneously.

Care Plans

While it is acknowledged that all of the residents had care plans in place they were incomplete and so did not reflect the individualised needs of the resident.

The Care Plans do not have provision for inserting a review date rather they have a heading of 'finish date' only, consequently this causes confusion as nurses are using this section to review care plans. There is no

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documentary evidence to show that the care plans are being evaluated on a planned regular basis.

Residents **, ** and *** care plans did not fully document the actual 'problem', consequently the interventions outlined were not reflecting the specific needs of these residents.

There was no residents name and number on the care plans.

Resident ** had care plans in place for 'Communication', Eating & Drinking' and 'Skin Condition' however it was not evident why this resident required these care plans as there was no problems or objectives documented.

This resident's care plan for 'Skin Condition' documented a requirement for a specialised pressure relieving mattress however it was also documented that this resident did not require the Waterlow Assessment

Residents **, ** and *** had a 'Psychological' Care Plan in place. However the problems outlined in the care plan were actually a series of questions while the nursing interventions outlined in the care plan were a series of assessments such as 'check blood sugar levels' and 'undertake blood analysis'. There was no correlation between the problem, objectives and interventions.

Resident *** had a care plan for 'Skin Condition' in place. The Nursing intervention requires the resident to be repositioned however there was no documentary evidence to show that this intervention was being undertaken.

Daily Nursing Notes

The Daily Nursing notes reviewed were not reflective of the plan of care or the care provided.

'Care rendered as per plan' was documented for Resident ** which is not reflective of the care required or provided. The 24hour clock is not being used.

The entries in the daily nursing notes are inconsistent and only when there is a change in the resident's condition or health status consequently one cannot ascertain the condition or status of the resident in a holistic and consistent manner.

The 24 hours clock is being used only intermittently.

The paper being used is photocopied and of very poor

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quality which results in great difficulty reading the hand writing of staff, for example the nursing narrative for resident ** dated 12/04/08 is in parts illegible.

Required Action

- (a) The nursing assessments to be a current reflection of the residents individualised and specific needs.
- (b) All nursing assessments and care plans have the resident name on, are signed and dated by the Registered Nurse. (*An Bord Altranais Recording Clinical Practice Guidelines to Nurses and Midwives, 2002*).
- (c) Risk Assessments and care plans have an implementation and review date documented.
- (d) The information obtained from the Nursing Assessment and Risk Assessment Tools are utilized in conjunction with professional judgment to formulate an individualized care plan. To minimise risk of miscommunication where possible use one care plan per identified problem.
- (e) Care plans based on nursing assessment are reflective of the specific care needs of the resident.
- (f) To minimise risk of miscommunication ensure that all resolved problems are clearly documented as resolved, and are signed and dated.
- (g) Numbering of care plans is clarified for staff and reflected in the Nursing Home Policy.
- (h) All residents have a comprehensive reassessment completed on a regular basis.
- (i) Criteria for reassessment to be incorporated into the Nursing Home Assessment/Reassessment Policy.
- (j) Audit of the Nursing documentation on a regular basis. (*An Bord Altranais Recording Clinical Practice Guidelines to Nurses and Midwives, 2002*).
- (k) The daily nursing narrative is an accurate and up to date record of the care provided and reflective of the care plan. This narrative to provide a comprehensive overview of the individuals current health status
- (l) The daily nursing note to document the 24hour clock in accordance with *An Bord Altranais Recording Clinical Practice Guidelines to Nurses and Midwives, 2002*.

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Timescale (a) to (j) Within two months of receipt of this Inspection report.
(k) & (l) Within 24 hours of receipt of this Inspection report.

Regulation number *19.1 In every nursing home the following particulars shall be kept in a safe place in respect of each dependent person:-
(g) a record of any accident or fall involving a dependent person;*

*12. The registered proprietor and the person in charge of the nursing home shall:-
(a) take precautions against the risk of accidents to any dependent persons in the nursing home and in the grounds of the nursing home;*

Non-Compliance

- On review of accident/incident records it was noted that resident's vital signs were not consistently recorded following incidents where residents sustained injuries.
- There is no fall prevention and management policy within the nursing home.
- Resident ** sustained a fall on 12/04/08 which required hospitalisation and treatment. The incident reporting book includes sections which makes provision for documenting 'referral for medical attention', 'referral to hospital' and 'diagnostics' these sections were not completed.
- Resident ** sustained a fall on 07/03/08, the incident reporting book was not completed in all relevant sections.

Required Action Person in Charge to:

1. Develop and implement a falls prevention and management policy.
2. Ensure following incidents/accidents involving residents that residents vital signs are consistently taken and recorded.
3. Develop a system in relation to the collection of incidents that allows for monitoring and analysis to identify risks and trends that will aid in evaluation.
4. Ensure that the current falls risk assessments outcome is reflected in the individual residents care plan.
5. Ensure that incident/accident reporting forms were completed accurately and fully in all

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	sections.
Timescale	1, 2, 3 & 4 Within one month upon receipt of this report. 5 Within 24 hours of receipt of this Inspection 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
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Comments and recommendations made by the inspection team as a result of the inspection	<p>The Designated Officers recommend that appropriate and relevant education and training be provided to the Nursing Home’s cleaning / household staff. This education and training should address such issues as cleaning and storage of mops, storage of chemicals, implementing cleaning schedule and maintaining appropriate records and infection control.</p> <p>The Designated Officers recommend where restraint is considered as required there be a comprehensive assessment undertaken to determine the appropriate type of restraint and the reason for the type of restraint used be documented. The form to be dated, signed and evaluation date documented. The form to document evidence of consultation with the next of kin, the nursing staff, the resident where appropriate and the GP. Where a resident is restrained documentary evidence to be provided showing the resident is mobilised every 2 hours or less.</p>
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This report has been completed/issued by	Noel Mulvihill LHO Manager
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