Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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Ms.Nicola Taylor
Proprietor
Brymore Nursing Home
Thormanby Road
Howth
Co.Dublin

Wednesday, 21 February 2007

Inspection Report
Re: Inspection of (Brymore Nursing Home) under the Health (Nursing Homes) Act, 1990 and the Nursing Homes (Care and Welfare) Regulations, 1993.

Dear Ms.Taylor,

The Health Service Executive Nursing Homes Inspection Team visited Brymore Nursing Home, Thormanby Road, Howth, Co.Dublin from 9.30 am to 15.30 pm on the 18th December 2006.

There were thirty nine residents on this date. The Nursing Home is currently registered for forty residents.

Issues identified at inspection on the 13th March 2006

Article 19
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;

(1) It was recommended that Care Plans be introduced which accurately reflect the residents assessed needs. At inspection on the 18th December 2006 it was noted by designated officers that the care plans do not accurately reflect the resident's needs in the daily nursing notes.

Following inspection of 18th December 2006, the following issues require your attention;

Article 5
The registered proprietor and the person in charge shall ensure that there is provided for dependent persons maintained in a nursing home
(b) a high standard of nursing care.

Breach(es)
On a review of the Pressure Area Risk assessments of the residents (Waterlow assessment tool is used in Nursing Home) the designated officers found
3 residents assessed as being "at risk"
14 residents assessed as being "high risk"
17 residents assessed as being "very high risk"

Nursing entries on the documentation used for Pressure Risk assessments for most of these residents are dated 11th and 13th August 2006. The actual Waterlow Assessments are for the majority of the residents is dated the 2nd September 2006.There is no documentation to state what nursing action was taken for any of these residents following their Pressure Area Risk assessments.

Required Action.
Document what nursing action is required for these residents.

Timescale
Immediately on receipt of Inspectors report.

Article19.
(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

Breach(es):
A
On an audit of the care plans and nursing records of four residents the designated officers found that whilst nursing assessments had been done there was no nursing action plan for most of the identified needs.
On reviewing the nursing records of five residents it was identified that the care plans were not clear as to

- The specific problems pertaining to the individual resident.

- The specific nursing intervention required.
- How the nursing interventions were documented in the daily nursing record of the individual resident.

1: (***). this resident's care plan only mentions how to deal with confusion and depression.
2: (***) Nursing assessment was done in June 2006 but there is no assessment date in resident's nursing records. Assessment also states that nursing evaluation is to be done in November 2006 but there is no documentation to show that this has been carried out. The Care Plan only mentions how to deal with the resident's breathing
3: (***) this resident was admitted to nursing home on the 4th September 2006 and the nursing assessment was only recorded as being done on the 17th November 2006.
4: (***) Nursing action plan only makes reference to disruptive behaviour.

B.
The documentation used for residents requiring wound care had no assessment tool or treatment chart It contained statements e.g. "wound improved " but it is unclear what it improved from.

Required Action
The Person in Charge to ensure that all residents have a full comprehensive nursing assessment. Once the nursing assessment has been completed and problems or potential problems identified a care plan should be initiated for each individual resident. The requirements of the care plan to include the following:

- Problem identification
- Each care plan must also include the assessed psychological and social needs of residents and the interventions to be carried out to meet needs.
- Specific nursing interventions to include how, when and who will carry out the interventions.
- Evaluation date
- All entries to the care plan must be dated
- The care plan interventions should then be reflected in the daily nursing records.

Timescale:
A
Immediately on receipt of inspection report for 1,2,3 and 4.
B
By 31st March 2007 for all residents.

Article 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 person in the nursing home and in the grounds of the nursing home

Breach(es)
The designated officers during inspection found
1:Uncovered Hot Water tank in the unlocked linen room.
2: Cleaning stores unlocked.
3: Wires at call bell in room 9 loose.

Required Action
1: Linen room to be locked and hot water tank to be covered.
2: Cleaning stores to be locked.
3:Loose wires at call in room 9 to be repaired.

Timescale
Immediately on receipt of report

The chairperson of the Inspection Team is to be notified on or before the above date(s) indicating the steps taken by the home to carry out the actions as required under the regulations.

_____ _____
Chairperson/Designated Officer Designated Officer

Cc Person in Charge.