	Nursing Home Inspection Report	
	Health (Nursing Homes) Act, 1990 and the Nursing Homes (Care and Welfare) Regulations, 1993.	
Nursing Home	Catherine Mc Auley House	Inspection Report
Number of Residents	23	
Registered for	26	
Nursing Home Address	Beaumount Dublin 9	
Proprietor	Sisters of Mercy	
Proprietor's Address (if different from above)	As above	
Person-in-Charge of Nursing Home	Helen Divilly	
Date and Time of Inspection(s)	14/03/2008	Findings
Date report issued	04/04/08	
Summary of previous report findings	Following the previous inspection from 31/08/07 the nursing home has not addressed non-compliance under the following regulations. Article 19.1(f)	
	Current Inspection Summary Findings	
Compliance status	Findings of latest unannounced inspection which took place on 14/03/2008 from 13.30hrs to 16.50hrs. The inspectors findings based on the current nursing home inspectorate regulations are as follows:	

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Summary Findings of Current Nursing Home Inspection	• **Under Care & Staffing the nursing home was compliant with 19 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. • **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.	Compliance/Non Compliance
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 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;* **29.1 (a)& (b)** — *The registered proprietor and the person in charge of the nursing home shall:—* *(a) make adequate arrangements for the recording, safekeeping, administering and disposal of drugs and medicines;* (*b) ensure that the treatment and medication prescribed by the medical practitioner of a dependent person is correctly administered and recorded.*	

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	Non-Compliance • On the day of inspection the Designated Officer reviewed a number of resident's medications administration records. The following issues were identified. • Resident ** had Senakot, two tablets charted to be administered at 18.00 hrs. There was no commencement date or doctors signature recorded. • Resident ** had a prescription for ********* 20mls at 10.00hrs and 22.00hrs. This medication was not recorded as administered at 10.00hrs on the 10th, 11th, 12th, 13th and 14th of March 2008, or at 22.00hrs on 10th, 11th, 12th, and 13th of March 2008. There was no record as to why this medication was not administered as prescribed. • Resident *** was prescribed *******, one daily. This medication was not recorded as administered at 11th, 12th 13th and 14th of March 2008. Betoptic eye drops were prescribed to be administered at 10.00hrs and 18.00hrs. This medication was not recorded as administered at 10.00hrs or 18.00hrs on the 10th, 11th 12th and 13th of March 2008. There was no record as to why these medications were not administered as prescribed. • Resident *** was prescribed tears naturelle three times a day. This medication was not recorded as administered on the 10th, 11th 12th and 13th of March 2008. There was no record as to why this medication was not administered as prescribed. On this residents medication administration record at 22.00hrs "*Tippex"* was used. • Resident *** was prescribed Difene Gel topically, three times a day. This was not recorded as administered at any time on the 10th, 11th, 12th and 13th of March 2008. There was no record as to why this analgesic medication was not administered as prescribed. • There were a number of medications on the drug administration trolley which had a requirement to "discard *one month after*

	opening" or *discard any unused medication after breaking the seal".* There was no date on these medications to indicate when they were opened and therefore it was not possible to determine when they should be discarded.
Required Action	*The person in charge to ensure that;* a) Ensure that all medication is administered as prescribed. Ensure that the reason for non-administration of medications is recorded accurately on the drug administration record. b) Ensure that all nursing staff administers medications in accordance of the "Guidance to Nurses and Midwives on Medication Management" July 2007. c) Update the current nursing home Medication Policy to incorporate An Bord Altranais, July 2007 Guidance to Nurses and Midwives on Medication Management". d) Regular audit of medications practice as recommended by .An Bord Altranais, July 2007 Guidance to Nurses and Midwives on Medication Management". e) Ensure that "Tippex" or "white out" is never used on nursing documentation.
Timescale	(a) & (b) & (e) immediately as discussed at the post inspection feedback. (c)Within two weeks on receipt of this report. (d) Within three months 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	The Designated Officers acknowledge that the nursing home have recently implemented a Model of Nursing and the Nursing Process as a method of care delivery in the nursing home. The Designated Officers acknowledge that there have been many improvements in the nursing documentation since the last inspection on 31/08/07 when the Model of Nursing was being piloted. However on the day of inspection there was no policy in place to support the Nursing Model in use. Of a random review of the nursing documentation the

Designated Officers noted the following areas for continued improvements in nursing documentation.

Care Plans.
Care plans were numbered accurately to reflect the activity that was assessed**.** Care plans were pre-printed with space to individualise the care plan/add further information. Some care plans were reflective of the needs of the resident. However this was not consistence among the individual files reviewed.

- Resident *** had care plans in place for many of the activities of daily living. Pain was identified as a problem for this resident on many of the documented problems under the activities of "*Sleeping"* and "*Cleansing and Dressing".* However there was no individualised care plan in place for "pain management". The resident was receiving regular analgesia. The care plans were evaluated on a regular basis. However evaluation of effectiveness of analgesia was not recorded.
- The Designated Officers acknowledge that the nursing home has a strong focus on promoting the residents independence. The resident's daily mobility is documented in a book on the unit. This information is not consistently documented in the care plan or reflected in the daily nursing notes.

Daily nursing Notes.

- The Designated Officers noted that the nursing notes were not always timed using the twenty four hour clock.

Wound Assessment

- There was not an accurate record of the resident's skin integrity which could identify the resident's current wound management requirements and progress. For example, resident *** had a wound assessment chart for two separate wounds. The last recorded entry relating to wound number one was on 05/03/08, which identified that a wound dressing was completed. The last recorded entry relating to wound number two (sacral pressure ulcer) stated "*dressing completed"* There was no further recorded updated record relating to these wounds. On the day of

inspection, 14/03/08 the daily activities form recorded that the pressure areas were red but intact, the daily nursing notes recorded "*dressing on back changed".* The Waterlow score was recorded as 30, indicating very high risk of pressure ulcers.

Reassessment.

- The nursing home documentation policy did not incorporate any information regarding reassessment of the residents. There was no evidence of a formal reassessment of the resident. On discussion with the PIC on the day of inspection she sated that care plans were updated monthly, but that there was no formal reassessment process currently in place.

Required Action	*The person in charge shall ensure that;* a) The nursing assessment is completed fully and accurately with the involvement of the resident or significant other if applicable. b) Care plans based on nursing assessment are reflective of the specific care needs of the resident. c) Problems/Needs identified are recorded under the appropriate activity of living. d) The nursing documentation is reflective of the resident's current condition. e) All residents have a comprehensive reassessment completed on a regular basis, at a minimum six monthly, or more frequently if there is a change in the resident's health status or following readmission from another facility. Criteria for reassessment to be incorporated into the Nursing Home Policy. f) Timing of entries in the daily nursing note must be made using the 24 hour clock *(An Bord Altranais Recording Clinical Practice Guidelines to Nurses and Midwives, 2002).* g) Audit of the nursing documentation on a regular basis. (An Bord Altranais) Recording Clinical Practice Guidelines to Nurses and Midwives, 2002).
Timescale	(a), (b), (c), (d) Within two weeks on receipt of this report. (e) Within one month on receipt of this report. (f) On receipt of this report (g) With four months on receipt of this report.

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Regulation number **Article 12.1**	*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;*
Non-Compliance	• The Designated Officers noted that there was a litre of *"bleach"* on the floor of the bathroom in the high dependency area. The Designated Officers also noted that there were two bottles of "spray cleaning solution" placed on the assisted bath in another bathroom in the nursing home. These chemicals posed a potential risk to the dependent residents in the nursing home. • The Designated Officers acknowledge that a falls prevention/management process is implemented in the nursing home. The Designated Officers acknowledge that incidents are "tracked" on an incident record and on an employees liability form. The tracking tool in place did not incorporate enough space to document "*action taken"* following an incident. However, there was no evidence of regular audit of incidents/accidents. The person in charge informed the Designated Officers that all incidents/accidents are reviewed "*at the end of the year".*
Required Action	*The person in charge to ensure that;* a) Chemicals are stored in a locked facility to ensure that they are not accessible to any residents. b) Staff has access to safety data information to ensure that the correct procedure is adhered to in the event of accidental spillage/ingestion of the chemicals. c) Incidents/accidents "tracking "tool requires further development to determine where possible the cause of the fall and action taken. d) Implement a regular audit system to monitor the incidents/cause and outcome of falls specific action plan.

	e) Staff education on points (a) (b) (c) and (d)
Timescale	(a) On the day of inspection as discussed with the Person in Charge at the post inspection feedback session. (b) & (c) Within two weeks on receipt of this report. (d) & (e) Within two months on receipt of this report.
Regulation number **Article 27.1**	*The registered proprietor and the person in charge of the nursing home shall:* *(a) take adequate precautions against the risk of fire, including the provision of adequate means of escape in the event of fire and make adequate arrangements for detecting, containing and extinguishing fires, for the giving of warnings and for the evacuation of all persons in the nursing home in the event of fire, and for the maintenance of fire fighting equipment.*
Non-Compliance	The Designated Officers noted that two stacks of plastic garden chairs and a garden table umbrella were stored on one side of the fire doors which led out to the garden. There were also two stools and a portable standing electric hair dryer stored on the other side of the fire doors. While the fire doors were not obstructed the storage of equipment on both sides of the door may impede evacuation of residents in the event of a fire.
Required Action	*The Person in Charge to ensure that;* (a) All items stored next to these fire doors are removed permanently. (b) Staff education is provided regarding fire the importance of keeping fire exits free from obstruction. (c) Fire exits are monitored for clear access on a regular basis as defined by nursing home policy.
Timescale	(a). Immediately as discussed at the post inspection feedback session. (b) & (c) Within one month on receipt of this report.
Regulation number Article 14.1	*The registered proprietor and the person in charge of the nursing home shall:—*

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	(b) make adequate arrangements for the prevention of infection, infestation, toxic conditions, or spread of infection and infestation at the nursing home;
	Non-Compliance: The Designated Officers noted that residents wash basins were stored on the floor in many of the resident's en-suite bathrooms. For example, in en-suite bathrooms number *, **, and **.
	Required Action: The Person in Charge to ensure that; (a). All wash basins are stored appropriately to minimise the risk of cross infection.
	Timescale: (a). Within one week 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 make the following recommendations: 1. All residents in shared accommodation have their denture containers labelled individually. Residents in shared accommodation have individual toiletry bags (for toothbrushes/ hairbrushes etc) labelled with the residents name. 2. Cease using the term "consent" on the restraint form unless the resident is consenting to the treatment of restraint. 3. The Designated Officers acknowledge that the nursing home monitor some of the residents vital signs when clinically indicated. The Designated Officers recommend that the nursing home implement a system of formally assessing, documenting and evaluating all residents' vital signs. 4. That all policies are reviewed and include the following information; • The implementation date. • The next review date. • The name and title of the person responsible for implementing, monitoring and updating the policy to be typed on the policy. • The signature of the person'(s) responsible for implementing, monitoring and updating the policy. 5. Implementation of a Protection of Older Adults/Abuse Policy and staff training on same. 5. The Designated Officers recommend that the complaints policy; • Is updated to reflect the current Director of Nursing's name on

Recommendations

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	Appendix 3 of the Policy. • That the "*verbal complaints register*" is utilised to document all verbal complaints as outlined in the policy. • That the *"verbal complaints register*" as outlined on Appendix 1 of the policy is utilised to audit and monitor verbal complaints on a regular basis.The Designated Officers recommend that this information is shared with staff in a proactive effort to resolve any resident/family/visitor issues at local level. • When documenting a residents nursing assessment refrain from describing the assessment of activities as "*normal"* i.e. normal diet/normal elimination pattern. Describe what is understood to be *"normal"* for the resident.	
This report has been completed/issued by	_____ Noel Mulvihill LHO Manager	Author