Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Nursing Home Inspectorate,
HSE Dublin North East Area,
2nd Floor, Ballymun Civic Centre,
Main Street,
Ballymun,
Dublin 9

Tel: 01-8467340
01-8467346

Fax: 01-8467508

Date: 20th September 2007

Mr. Harry McElhinney and Mrs. Margery McElhinney,
Registered Proprietors,
Clontarf Private Nursing Home,
5 – 7, Clontarf Road,
Clontarf,
Dublin 3

Inspection Report

Re: Inspection of Clontarf Private Nursing Home, 5 – 7, Clontarf Road, Clontarf, Dublin 3 under the Health (Nursing Homes) Act, 1990 and the Nursing Homes (Care and Welfare) Regulations, 1993.

Dear Mr. & Mrs. McElhinney,

The Health Service Executive Nursing Home Inspection Team from the Medical and Nursing perspective inspected **Clontarf Private Nursing Home** on **8th August 2007.**

The inspection commenced at **09.00 a.m.** and was completed by **02.15 p.m.** This is a **routine re-registration** inspection and **unannounced.**

There were **43 residents** on this date. The Nursing Home is currently **fully registered** for **45 residents.**

Issues identified in the previous Inspection Report dated **18th July 2007:**

The following Articles have been satisfactorily addressed.

- **Article 12 (a):** *Wire extension sockets in Room 6 and Oxygen cylinders in Room 10 - Required Action 1 & 2 addressed*
- **Article 19.1 (f):** *Allergies section in drug prescription records & Use of tippex in documentation records – Required Action 1, 2 & 3 addressed*
- **Article 14 (a):** *Commode in Room 20 – Required Action addressed*

Recommendations:

- **Storage of commodes in assisted shower room** – *Issue satisfactorily addressed*
- **Auditing of Accident/ Incidents forms** – *Issue not yet addressed*

Current Inspection

The following issues require your attention and action:

Article 19.1 (d)

Article 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

Issues:

1. A random sample of Nursing Care Plans was reviewed and the following issues were identified:

   i. Patients ** & ** had long term catheters in place. While there was a generic Catheter Care Plan in place, the assessment/reason for the insertion of the catheters was not evident from the nursing notes or care plan. There was no reassessment date as to the need for a catheter or the recommended replacement dated for the catheters on either Care Plan.

   ii. It was not evident from the Nursing Care Plans or daily nursing notes the frequency, for changing the urine collection bags.

Required Action

1. Please include the following detail in the Care Plans relating to Urinary Catheters:
    a. Reason for catheter
    b. Date Catheter inserted
    c. Type of catheter
    d. Reassessment date
    e. Replacement date of catheter dependant on type
    f. Signature of nurse who replaces the catheter

2. Frequency of urinary collection bag change to be indicated on care plan. Establish a method to ensure this is monitored and adhered to.

Timescale:

1 & 2: To be addressed within two weeks following the receipt of this report

Article 12 (a) & Article 19.1 (g)

Article 12: *The Registered Proprietor and the Person In Charge of the Nursing Home shall:*

(a) take precaution against the risk of accidents to any dependent person in the Nursing Home and in the ground of the Nursing Home

AND

Article 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

Issues:

1. During inspection, Designated Officers observed that Resident ** had an injury to her forearm which was not documented in the daily nursing record. There was no record of incident report evident on cross-referencing this with the accident/ incident records. There was also no Wound Care Plan in place on review of the Nursing documentations

2. It was also recorded in the daily nursing notes of Resident ** had an incident occurring on ** at **p.m. where she was found on the floor by the Nursing Home staff. There was no record of this on review of the accident/ incident records

3. In the last inspection report dated18th July 2007, Designated Officers noted there was no action taken to audit the Accident/ Incident Forms. The Designated Officers recommended commencement of regular auditing of all

accidents/ incidents in relation to a Risk Assessment analysis. This was also recommended by previous inspectors in 2006. However, on this inspection conducted on the 8th August 2007, the Designated Officers noted that the Nursing Home has not yet undertaken the action to audit the Accident/ Incident Forms.

Required Action

1. All incidents/accidents must be reported and have an incident report form completed in accordance with the Nursing Home Policy document

2. Instigate auditing of the incident and accidents in order to monitor and maintain standards as recommended in "Recording Clinical Practice Guidelines" by An Bord Altranais (2002).

Timescale:

1. To be addressed within twenty-four hours following the receipt of this report

2. To be addressed within one month following the receipt of this report

Article 19.1(f)

Article 19.1: *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

Issue

1. Resident ** 7/07/07 Glugophage MD dose was not signed as given and no reason for the omission was noted on the drug kardex..

2. Resident ** was prescribed Motilium TDS on 3/07/07 but only one dose was administered and signed for on 6/08/07. There was no reason noted on the drug kardex for the omission.

Required Action:

Ensure all medication administration or non-administration is documented in accordance with An Bord Altranais "Guidance to Nurses and Midwives on Medication Management" (2003) 2.1(f) iv & (i) iii

Timescale:
Immediately on day of inspection as outlined by the Designated Officer to the Registered Proprietor and the Person In Charge during the Post Inspection Feedback Meeting

Article 12 (b)

Article 12: *The registered Proprietor and the Person in Charge of the Nursing Home shall:*

> *(b) ensure that handrails are provided in circulation areas and that grab-rails are provided in bath, showers and toilet areas*

Issue
During inspection, Designated Officers noted that there was no handrail provided in the corridor of the lower ground floor of the Nursing Home where a number of residents' rooms are located.

Required Action
Please install a handrail along all public corridors as outlined in Article 12 (b) of the Care & Welfare Regulation 1993 above

Timescale
2 weeks following the receipt of this report

Recommendations:

1. **Use of abbreviations**: A number of abbreviations were noted in the Nursing Documentation which were not reflected in the Nursing Homes acceptable list of abbreviations. The Person in Charge must ensure that only the listed acceptable abbreviations are used. The instigation of a documentation audit could assist with this.

2. **Blood Sugar Monitoring**: Ensure nursing staff adhere to the frequency outlined in the Care Plan or adjust the care plan accordingly.

3. **Dementia Training**: As recommended in previous inspection report dated 14th February 2006, we acknowledge that the training is currently being organized by the Nursing Home. A number of staff has been booked for the next available Dementia Training in St. James's Hospital in September 2007. We advise the Nursing Home to provide evidence of the training attendance as soon as it is available

4. **Room **:** During inspection, Designated Officers noted that the bedside socket is damaged and in need of repair. Registered Proprietor and Person in Charge was made aware of this during inspection

The Nursing Home Inspection Team is to be notified in writing on or before the above dates indicating the steps taken by the Nursing Home to carry out the actions as required under the Regulations.

Signed:

_____	_____
Designated Officer/ Chairperson, Nursing Home Inspectorate, Dublin North East	Designated Officer, Nursing Home Inspectorate, Dublin North East
_____	_____
Designated Officer, Nursing Home Inspectorate, Dublin North East	Designated Officer, Nursing Home Inspectorate, Dublin North East

Signed counterpart sent to Ms. Catherine O'Leary, Registered Person In Charge, Clontarf Private Nursing Home