	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	26
Registered for	28
Nursing Home Address	Cabra Dublin 7
Proprietor	Anne 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)	20/11/2007 12 Midday to 16:00
Date report issued	5th December 2007
Summary of previous report findings	Following the previous inspection from 29/01/07, the nursing home has not addressed non-compliance under the following regulations. Article 19.1 (d)
	Current Inspection Summary Findings
Compliance status	**Findings of latest (unannounced) inspection which took place on 20/11/2007** 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 with out 18 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 11 out of 11 regulations.**

  On the basis of this inspection and under current nursing home regulations, the inspection team would consider the nursing home provides a good Physical Environment for residents.

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	Article 18.1 (e) (f) & (g)
Non-Compliance	On review of the register on the day of Inspection the Designated Officers noted that the following information was not recorded: (e) Residents **, ** & ** had left the nursing home and had no forwarding address recorded. (f) Resident ** did not have the reason for their admission to hospital recorded in the register. (g) Two residents who died in the nursing home did not have the certified cause of death documented in the register.
Required Action	The Person in Charge to ensure that the bound register includes all the information required under Article 18.1 (a) to (g)
Timescale	Within one week of receipt of this report.

Compliance/Non Compliance

Nursing Home Inspection Report

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

Regulation number	Article 19.1 (c)
Non-Compliance	On the day of the inspection, Designated Officers noted a number of issues in relation to resident's assessments following admission into the Nursing Home: a. Resident ** was reviewed by the GP following admission into the Nursing Home, but there were no details of a background medical history recorded in the medical notes. There was also no transfer/ hospital discharge letter available in the medical notes to confirm a full background medical assessment. On the 06/06/06, Designated Officers noted the GP recorded "Need to clarify PMHx (Past Medical History)", but the information continues to be unavailable in the medical notes. On review of the Nursing Documentation it is recorded that the resident has a background history of Osteoarthritis, Congestive Cardiac Failure, Bilateral crepitus and Cellulites. However, on review of the resident's drug prescription record, it was noted that the resident is currently on Eltroxin (a thyroid supplement drug). Review of the drug administration sheet reveals that the medication was signed as given. There was no record in the medical or the nursing documentation that Resident ** was recently diagnosed or had a background history of thyroid related problems. b. Resident **'s drug allergy status was not recorded in the medical notes, the Nursing documentation or the Drug Prescription Record. A review of the drug administration sheet however indicated that all her medication was signed as given following her admission into the Nursing Home. There is no evidence as to whether this resident has any drug allergies. Similar findings were also noted on Resident **. medical, nursing and medication records.

Nursing Home Inspection Report

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

Required Action	Person In Charge to ensure that: 1. A full background medical history of the resident to be obtained and made available (either queried and recorded by the GP in the medical notes or listed in the transfer/ hospital discharge letter) in the medical and nursing records of each resident in the Nursing Home. Each medications administered to the resident should reflect the resident's medical history. 2. The resident's possible medication allergy should be enquired and recorded accordingly following admission into the Nursing Home, before any medication is administered to the resident.
Timescale	1 & 2 within 2 weeks of this report
Regulation number	Article 19.1 (d)
Non-Compliance	The Designated Officers would like to acknowledge the continued improvement in the nursing documentation. It is also acknowledged that a Clinical Nurse Manager has been successfully recruited and will be focusing on the continued development of the nursing documentation. On the day of Inspection the following issues were identified: **Assessment** An assessment on admission had been completed for each resident reviewed. Some of the information was not recorded/ captured correctly on this form. For example residents **, **, ** & ** in the Section for allergies under the subsection for Medication had a full list of medications recorded and not the medications the resident was allergic to. The following residents did not have a recent Activities of Living reassessment undertaken: ** last Assessment of Living done 24/02/07 ** last Assessment of Living done 6/02/07 ** last Assessment of Living done 1/08/07 ** last Assessment of Living done 6/3/07

Care Plan
The Care Plans are in a generic typed format.
The "review date" and the "finish dates" are not being recorded in a consistent manner which did not identify a clear review date.

The generic typed care plans are not being adjusted to reflect the individualised needs of each resident as in the case of **, ** & **.

Resident ** on 11/11/07 in the narrative notes was identified as being "very aggressive". On 17/10/07 it was documented that this resident was "aggressive" and had "pinched staff". It was also noted that 2 incident forms were completed by staff when this resident had scratched them. There was no care plan in place to highlight that this resident could be aggressive at times.

Daily Note
A tick list is utilised to record the daily care which is supplemented with a narrative note when required. These narratives note needs to be detailed enough to ensure all information is recorded accurately as in the case of ** who on 7/11/07 "attended the clinic for injection and blood sample". The narrative nursing notes did not include any other information to identify what the injection or blood tests are or if any post care is required.

Required Action

The Person In Charge is to ensure that

1. All nursing staff complete the assessment documentation in a clear and consistent manner to ensure that the information required to provide adequate nursing care is captured.

2. The Activities of Living assessments are updated and recorded as reassessed on a regular basis to ensure that a current status of the residents needs are clearly documented.

3. All nursing staff clearly understands the format of the care plans to ensure that the review date and finish date is correctly documented.

4. Each care plan is adjusted to reflect the individualised care needs of each resident.

5. Each resident has care plans specific to their

	Nursing Home Inspection Report Health (Nursing Homes) Act, 1990 and the Nursing Homes (Care and Welfare) Regulations, 1993.	
	individual needs. 6. The daily nursing note provides an adequate nursing record of the person's health and condition and treatment given and give a clear picture of the persons condition and care to anyone reading them as outlined in " Recording Clinical Practice guidance to Nurses and Midwives" 2002. Timescale Within 2 months of 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 would recommend that a procedure is put in place to ensure the MDA stock count is recorded at the handover of each shift by a nurse from each shift in accordance with section 2.13 of the "Guidance to Nurses and Midwives on Medication Management" (July 2007)	Recommendations
This report has been completed/issued by	Noel Mulvihill, LHO Manager	Author