Dear Mr & Mrs Joe Kenny

Proprietors
St. Pappin’s Nursing Home
Ballymun Road
Ballymun
Dublin 9

Tuesday, 28 August 2007

Inspection Report

Re: Inspection of St Pappin’s, Ballymun Road, Ballymun, Dublin 9, under the Health (Nursing Homes) Act, 1990 and the Nursing Homes (Care & Welfare) Regulations 1993

The Health Service Executive Nursing Homes Inspection Team inspected St Pappin’s Nursing Home Ballymun Nursing Home Ballymun Road, Dublin 9 from 10.00hrs to 16.00hrs on the 21/03/2007 and 20/07/07 from 14.45hrs to 15.30 hrs. This inspection was routine and unannounced.

There were fifty six (56) residents on the 21/03/2007. The Nursing Home is currently fully registered for fifty nine (59) residents.

Issues identified in previous Inspection 22/11/06

The following
Articles 29, 12, 5, 14 have been satisfactorily addressed.
Articles 19.1 have been partially addressed.

The following issues require you attention
Article 19.1

In every nursing home the following shall be kept in a safe place in respect of each dependent person

(c) a record of the medical and nursing condition of the person at the time of admission
(e) a medical record with details of investigations made, diagnosis and treatment given, and a record of all drugs and medicines prescribed, signed and dated by a medical practitioner

Non-Compliance

On review of the medical documentation, and a telephone conversation with the GP, the Designated Officer was informed that there are currently two sets of medical notes available for the residents in the Nursing Home, one available on site within the nursing home, while the other is available in the GP’s surgery in Glasnevin. The notes in Glasnevin are the most up-to-date, while the notes in the Nursing Home are only used when the GP is seeing residents at the Nursing Home.

On review of a random sample of 25 medical notes in the nursing home

1. A number of notes were last dated May 2006
2. Most of the admission notes were simply noted ‘Admission’ with lack of any other medical details to indicate a brief summary of resident’s condition at time of admission, examination during time of admission, past medical history allergies etc.
3. No adequate details of any investigations made, diagnosis and treatment given recorded
4. Two residents in St Pappin’s (Resident ** and **) do not have any medical notes available in the Nursing Home. The Designated Officer was informed that this is because they were examined by the residents own GP.

Required Action

All residents to have up-to-date notes in line with the information outline in Article 19.1 (c) and (e)

A medical record on all residents must be available in the nursing home

Timescale

Three months following the receipt of this report

Article 19.1

(d) an adequate nursing record of person health and condition and treatment given completed on a daily basis and signed and dated by nurses on duty

Recommendation

While it is acknowledged that for the most part the care plans are comprehensively written the section on ‘Intervention’ needs to be more descriptive in nature. When using the nursing process it is necessary to identify and delegate responsibility for each step. This then allows for appropriate evaluation which not only involves analyzing the success of the goals and interventions, but examining the need for adjustments and changes as well.
**Article 11.2**
In every nursing home there shall be provided suitable and sufficient accommodation which meets the minimum standard as follows

(a) adequate accommodation and space in single and shared sleeping rooms an portable screens or screening curtains to ensure privacy for individual persons.

**Non Compliance**
It was noted on both dates of inspection 21/03/07 and 20/07/07 that dependent persons are maintained in the two beds nearest the door in room **. This in contravention of the condition of registration which stated ‘The inspection team recommend registration of St Pappin’s Nursing home for: 59 persons ........ with the condition attached that low dependency residents occupy the two beds beside the doors in Rooms 34 until alterations to bed layout are carried out by the proprietor’. [Dated 3rd March 2003].
To date these alterations have not been carried out.

**Required Action**
1. Relocate the two residents in these beds to more suitable accommodation given the nature of their dependency or
2. Make the necessary alterations suggested/recommended at time of registration.

**Timescale**
Within 2 months on receipt of this report.

**Article 10.5**
The registered proprietor and the person in charge of the nursing home shall ensure that

(d) a sufficient number of competent staff are on duty at all times having regard to the number of person maintained therein and the nature and extent of their dependency

**Issue**
A number of residents (39) in the home have some degree of dementia. Staff have not had dementia specific training since 2004 in some instances for both nursing and care staff and 2005 in other instances, while only 2 staff have training so far in 2006.

**Required Action**
1. Establish staff competency in relation to dementia care and devise a training programme accordingly
2. Forward a schedule of ongoing education in dementia specific training to inspectorate.
3. Ensure all staff who have contact with residents with dementia are competent in dementia care
**Timescale**

1 & 2 Within three months on receipt of this report
2 Within three months on receipt of this report and continuous

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.

**Your immediate attention to this report is requested.**

Signed:

_________________________________  ___________________________
Designated Officer/Chairperson.                  Designated Officer