Inspection Report


Dear Mr Shanahan

The Health Service Executive Nursing Home Inspection Team from a Medical and Nursing perspective inspected Swords Nursing Home on 13th August 2007.

The inspection commenced at 11:00am and was completed by 16:00. This inspection was a routine unannounced inspection.

There were 25 residents on this date. The Nursing Home is currently fully registered for 60 residents.

Issues identified in the previous Inspection Report dated 7 & 11/06/07:

The following articles have been satisfactorily addressed: Articles 14 (b), 5(a) & (b), 19.1(d) & (e), 28.1(a), (b) & (c) 27.1(b), 13(a)

The following article has been partially addressed and is ongoing 10.5(d)
Current Inspection

The following issues require your attention and action.

Article
19.1 In every nursing home the following particulars 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;

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;

Issue
Of the random sample of drug administration forms reviewed, the section where drug allergies should be inserted was left blank in some cases.

Required Action
1. Insert drug allergies or ‘none known’ in the section identified on the drug administration form.
2. No blanks should be left on any documentation.

Timescale
1 & 2: To be addressed within one week following the receipt of this report.

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

( 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;

Issue
While reviewing the computerized nursing documentation, Designated Officer noted that Resident ** had a weight loss of 8.5 kg on the 16/6/07. Resident ** then gained 2.2 kg on the 7/7/07 and this is followed by a 1.65 kg weight loss on the 15/07/07. Designated Officer also noted in the nursing documentation that the resident was seen by the GP at least three times in relation to this weight loss issue. However, on cross-referencing this with the medical documentation, there was no recorded evidence available to indicate that this weight loss issue was documented by the GP.
**Required Action**
The Registered Proprietor and the Person in Charge to ensure that all medical reviews and assessments are recorded appropriately following each GP review to satisfy the requirement Article 19.1 (e) outlined above.

**Timescale**
To be addressed within 24 hours following the receipt of this report.

**Recommendation**

1. It is recommended that temperature recording to be consistently recorded in either Fahrenheit or Celsius.

The Chairperson of the Inspection Teams to be notified in writing on or before the above dates the steps taken by the nursing home to carry out the actions as required under the regulations.

Signed:

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Designated Officer/Chairperson.                  Designated Officer

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Designated Officer