	Nursing Home Inspection Report Health (Nursing Homes) Act, 1990 and the Nursing Homes (Care and Welfare) Regulations, 1993.
Nursing Home	San Remo Nursing Home
Number of Residents	47
Registered for	51
Nursing Home Address	14/15 Sidmonton Road Bray Co. Wicklow
Proprietor	Dr Evelyn Barrett Willis & Mr Robert Willis
Proprietor's Address **(if different from above)**	
Person-in-Charge of Nursing Home	Carmel Kearns, RGN
Date and Time of Inspection(s)	11/06/2009 10.15 - 14.30
Date report issued	
Summary of previous report findings	The previous inspection from 18/12/2008 showed the nursing home to be substantially compliant with current nursing home inspectorate regulations at the time of inspection.
	Current Inspection Summary Findings
Compliance status	**Findings of latest (unannounced) inspection which took place on 11/06/2009 10.15 - 14.30** 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 22 out of 25 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 23 out of 23 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.

Compliance/Non Compliance

Non-Compliance

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 5 Welfare and Wellbeing** The registered proprietor and the person in charge shall ensure that there is provided for dependent persons maintained in a nursing home: (a) suitable and sufficient care to maintain the person's welfare and well being, having regard to the nature and extent of the person's dependency (b) a high standard of nursing care
Non-Compliance	1. A number of Residents identified as being at high risk for the development of pressure ulcers had not been reassessed at a minimum on a three monthly basis 2. A number of Residents identified as being at high risk for the development of pressure ulcers did not have a specific care plan in place regarding the prevention and management of pressure ulcers

3. One Resident who has a pressure ulcer and whose nursing records indicate that this is painful did not have a pain care plan in place

Required Action	**1-3** (A) All Nursing staff should receive update training in 1. Patient assessment 2. Risk assessment 3. Nursing Care Planning 4. Nursing documentation And ensure that the appropriate risk assessments are carried out on all current residents as appropriate, and the outcome of each risk assessment is reflected in the individual's clinical assessment and care plan. This should then be reviewed and reported on in line with best practice The care plans must be patient specific. Once the assessment has been completed and problems or potential problems identified a care plan should be initiated for the patient. The requirements of a care plan include the following: • Problem identification • Goal specification • Specific nursing interventions to include how, when and who will carry out the interventions within a specified time-frame. • Review date • All entries in the care plan must be dated and signed by the person who has formulated the plan The plan should then be reflected in the daily nursing notes (nursing kardex)
Timescale	Two months from receipt of this report
Regulation number	**Article 19 Register and records** In every nursing home the following particulars shall be kept in a safe place in respect of each dependent resident (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

Nursing Home Inspection Report

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

Non-Compliance	1. In relation to a number of Residents there was not an adequate nursing record of the person's health and condition and treatment given, completed on a daily basis. Their nurses' note recorded "All care given" "All care maintained" "All care as before" "All care rendered as before" 2. Wound assessment & management documentation is inadequate in reflecting current expected standards in wound care. There is no space allocated on the assessment chart for • % wound bed tissue type • Infection
Required Action	**1-2** (A) All Nursing staff should receive update training in nursing documentation (B) All nurses should be referred to An Bord Altranais Guidelines on Nursing Documentation and nurse managers should ensure that staff understand and implement best practice procedures and protocols. (C) Systems need to be put in place to ensure that adequate nursing records of all residents' health, welfare, conditions and treatment given are completed on a daily basis and signed and dated by the nurse on duty (D) Wound assessment/management documentation requires updating. A standardised wound assessment/management tool such as that developed between St. James's Hospital, Tallaght Hospital & Dublin Community Care should be implemented.
Timescale	**A- C:** One Month from receipt of this report
Regulation number	**Article 19.1** In every nursing home the following particulars shall be kept in a safe place in respect of each dependent resident (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 nurses administering the drugs and medicines "
Non-Compliance	In relation to one Resident it was noted that the route of administration of their Galfer was not specified
Required Action	(A)The Prescribing GP should be asked to specify the route of administration on the prescription (B) All nurses need to be referred An Bord Altranais Guidance to Nurses and Midwives on Medication Management 2007. Nurse Managers must ensure that these guidelines are implemented by all staff and that systems are put in place to support implementation of best practice guidelines.
Timescale	Immediately on receipt of this report

Regulation number	**Article 29 Medical preparations** The registered proprietor and the person in charge of the Nursing Home shall: (a)Make adequate arrangements for the recording, safe keeping, administering and disposal of drugs and medicines (b)Ensure that the treatment and medication prescribed by the medical practitioner is correctly administered and recorded
Non-Compliance	It was noted that a number of Residents who were prescribed and administered _____ did not have their heart rates recorded prior to the administration of the medication in line with best practice and safe administration of this drug
Required Action	All nurses need to be referred An Bord Altranais Guidance to Nurses and Midwives on Medication Management 2007. Nurse Managers must ensure that these guidelines are implemented by all staff and that systems are put in place to support implementation of best practice guidelines.
Timescale	Immediately on receipt of this report

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

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	1. Best practice would indicate that the Waterlow assessment should be carried on those identified at risk at a minimum every three months or more frequently if their condition indicates 2. Best practice would indicate that the Nutritional screening assessment should be carried out on those identified at risk at a minimum every three months or more frequently if their condition indicates 3. All nursing notes should be recorded using black ink and the 24 hour clock 4. The use of sheepskins and sudocreme for the prevention or management of pressure ulcers is no longer in line with recommended or best practice
This report has been completed/issued by	Ms. Marion Meany, A/Local Health Manager, Wicklow

Recommendations

Author