Nursing Home Inspection Report

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

Nursing Home	Aisling House Nursing Home
Number of Residents	19
Registered for	31
Nursing Home Address	Ferrybank Seabank Arklow Co. Wicklow
Proprietor	Hussein & Jan Ali
Proprietor's Address (if different from above)	
Person-in-Charge of Nursing Home	Ms Anna Szezepanska
Date and Time of Inspection(s)	27/5/2009 10.30 - 14.30
Date report issued	
Summary of previous report findings	Following the previous inspection from 09/03/2009, the nursing home has addressed all non-compliance issues outlined in the report.

Inspection Report

Findings

Current Inspection Summary Findings

Compliance status	**Findings of latest (unannounced) inspection which took place on 27/5/2009 10.30 - 14.30** The inspectors findings based on the current nursing home inspectorate regulations are as follows:

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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.

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	**A.** In relation to ******* There was failure to include/update the following individual patient care needs in ___ Nursing Care Plan. 1. There was no evidence of risk assessments being carried out in relation to the prevention and management of Pressure ulcers, Nutrition or falls 2. ___ Nursing notes indicate that on ________

Compliance/Non Compliance

____ that ________________ were _______..
There would not appear to have been any follow up on this observation. ___ nursing care plan was not updated to reflect this.

3. This Resident is prescribed and has been administered ____ on a daily basis yet ___ ______ have not been documented since January 1st 2009.

B. In relation to *******:

There was failure to include/update the following individual patient care needs in ___ Nursing Care Plan.

1. There was no evidence of risk assessments being carried out in relation to the prevention and management of Pressure ulcers, Nutrition or falls despite the fact that this Resident is __________ and requires the use of a _____
2. There was no daily reference to the condition of ___ skin/pressure areas in the nursing notes as per risk category
3. There was no pressure ulcer prevention/management care plan in place

C. In relation to **********

There was failure to include/update the following individual patient care needs in ___ Nursing Care Plan.

1. There was no evidence of risk assessments being carried out in relation to the prevention and management of Pressure ulcers, Nutrition or falls
2. There was no daily reference to the condition of ___ skin/pressure areas in the nursing notes as per her risk category
3. There was no nursing care plan in relation to ___ nutrition despite the fact that ___ is on a ____ ____ and on ___ _________ __________
4. There was no wound assessment record in relation to the dressings being carried out on ___ ______ ______ and ______ ______

D. In relation to *******

There was failure to include/update the following individual patient care needs in ___ Nursing Care Plan.

1. There was no evidence of risk assessments being carried out in relation to the prevention and management of Pressure ulcers, Nutrition or falls
2. There was no nursing care plan in relation to the prevention and management of pressures ulcers
3. There was no daily reference to the condition of ___ skin/pressure areas in the nursing notes as per ___ risk category
4. There was an insufficient care plan in place in relation to ___ nutrition and ___ is on _____
5. ___ output was recorded as intake and there is no evidence to suggest that ___ indeed had any output on ___ intake and output chart

E. In relation to ********** admitted the **** preceding the inspection**:**

There was failure to include/update the following individual patient care needs in ___ Nursing Care Plan.

1. There was no evidence of risk assessments being carried out in relation to the prevention and management of Pressure Ulcers, Nutrition or Falls
2. _____ Nursing assessment was found to be incomplete
3. There was no baseline respiratory rate recorded on admission
4. This Resident is prescribed and has been administered _______ on a daily basis yet ___ _____ has not been documented on a daily basis.

F. In relation to **********:**

There was failure to include/update the following individual patient care needs in ___ Nursing Care Plan.

1. There was no evidence of risk assessments being carried out in relation to the prevention and

management of Pressure ulcers, Nutrition or falls
2. There was no Pressure Ulcer prevention and management care plan in place
3. There was no care plan in place in relation to the use of restraints
4. There was no reference to the use of restraints in ___ nursing notes

Required Action

re A – F above:

1. <u>All Nursing Staff should receive update training in:</u>

I. Patient assessment
II. Risk assessment
III. Nursing Care Planning
IV. 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.
Required Action	**2.** Additional training should be provided in proper nutrition and hydration of the older person .Staff should also be educated further in the significance of weight loss to the older person and in monitoring weight closely and acting appropriately when weight loss is identified as a problem **3.** Additional training should be provided to all Nursing Staff and HealthCare Assistants on best practice in the prevention and management of pressure ulcers
Timescale	**2 & 3, inclusive, above:** **One month from receipt of this report.**
Regulation number	**Article 19.1 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
Non-Compliance	**1.** In relation to the following Residents: ******** ******** *********** ******* There was not an adequate Nursing Record of the person's health and condition and treatment given, completed on a daily basis. Most of their nurse's note recorded:- "Good Day " "No Change" "All care given" "All care maintained" "Comfortable day" "Comfortable night"

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2. In relation to ********:**

There was no nursing note for the night shift of ______________. A line was left blank for the entry to be made retrospectively

Required Action	I. All Nursing staff should receive update training in nursing documentation II. 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. III. 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
Timescale	Two Months 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	**1.** All of the prescription sheets and administration records are maintained on a photocopied drug record as opposed to an original printed record **2.** In the majority of records reviewed the frequency of the drug is not specified but rather indicated by a tick mark which could easily be altered

3. In all of the records reviewed at the time of inspection from 1000 Hrs onwards the 0800 medications had been administered as per the Nurse in charge yet they had not been signed in the administration record as having been administered
4. Resident *** is prescribed the following medications where the route of administration is not specified – __________, ________, _____________ and _________
5. Resident *** was prescribed ________ and the route of administration was not specified nor was the prescription signed off by a doctor yet it had been administered between __________ and ________ inclusive.
6. Resident *** is prescribed a _____________ ___ but it does not specify the frequency of which this can be administered.
7. In relation to Resident ***, __ is also prescribed ________ but there is no route of administration specified. There are ___ medications prescribed for this resident and there are only two signatures for all ________ medications
8. Resident *** is prescribed _______ but there is no route of administration specified
9. Resident *** is prescribed _______ that has been administered that is not signed off by a doctor.
10. In relation to Resident *** the following medications have been prescribed without a route of administration being specified – _______ _______ _______ _________ __________ _______
11. Resident *** is prescribed and has been administered ______ on a daily basis yet ___ ____ _____ have not been documented since January 1st 2009.

Resident *** is prescribed and has been administered ______ on a daily basis yet ___________ has not been documented on a daily basis.

Required Action

I. All nurses need to be referred An Bord Altranais Guidance to Nurses and Midwives on

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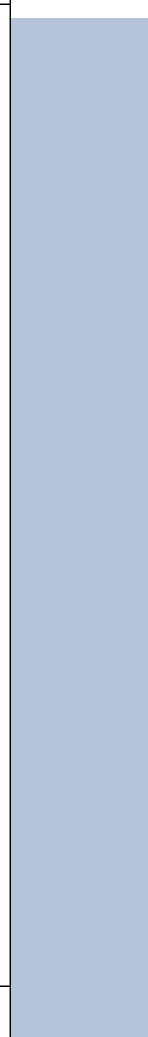
Medication Management 2007. Nurse Managers must ensure that these guidelines are implemented by all staff and that systems are put in place to support implementation of best practice guidelines.

II. All drug records need urgent review and need to be rewritten where errors or omissions are identified

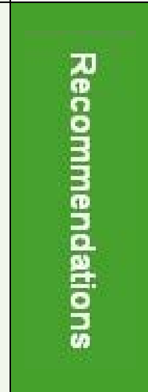
Timescale	Immediately on receipt of this report
Regulation number	**Article 29 Medical preparations** The registered proprietor and the person in charge of the Nursing Home shall: (a)Make adequate arrangements for the recording, safe keeping, administering and disposal of drugs and medicines
Non-Compliance	It was noted that the drug trolley which contains the MDA cupboard was not secured to the wall where it was stored in a open public hallway.
Required Action	The drug trolley must either be stored in a locked room which only staff have access to or should be secured to the wall when not in use
Timescale	Immediately on 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



1. As discussed all residents should at a minimum have a nutritional, falls and pressure ulcer risk assessment carried out on admission. Where a risk is identified reassessment should be carried out at a minimum on a three monthly basis and more frequently if their condition warrants. The nursing care plans and nursing notes should also be updated to reflect theses changes.

2. At the time of the inspection it was identified that all relevant policies were not in place. These need to be devised/updated and implemented as a matter of urgency. The Nursing Home staff

need to be familiar with these policies and need to adhere to them once implemented.

3. All nursing notes should be recorded using black ink and the 24 hour clock

4. In the majority of the records reviewed the drugs had been transcribed which is not in line with best practice." An Bord Altranais Guidance to Nurses and Midwives on Medication Management 2007.

This report has been completed/issued by	Ms. Marion Meany, A/Local Health Manager, Wicklow	Author