LEGAL NOTICE NO. 80

REPUBLIC OF TRINIDAD AND TOBAGO

THE PRIVATE HOSPITALS ACT, CHAP. 29:03

REGULATIONS

MADE BY THE MINISTER UNDER SECTION 27 (1) OF THE PRIVATE HOSPITALS ACT

THE PRIVATE HOSPITALS (AMENDMENT) REGULATIONS, 1992

Citation

1. These Regulations may be cited as the Private Hospitals (Amendment) Regulations, 1992.

Regulation 2 amended

2. Regulation 2 is amended—

(*a*) in subregulation (1) by—

(i) substituting a semicolon for the full stop at the end of paragraph (*d*);

(ii) adding after paragraph (*d*) the following paragraph:

"(*e*) in the case of a home for the elderly, be a nurse."; and

(*b*) by inserting after subregulation (2) the following subregulation:

" (2A) At all times there shall be a medical practitioner on call and readily available to every home for the elderly.".

Regulation 3 amended

3. Regulation 3 is amended by renumbering it as subregulation 3(1) and inserting after subregulation 3(1) as amended the following subregulation:

" (2) There shall be on duty at all times in every home for the elderly one staff member for every five patients, the minimum number of staff members on duty at all times being two, one of which shall have such training and experience in the care of the elderly as may satisfy the Board.".

Regulation 4 amended

4. Regulation 4 is amended—

(*a*) by repealing the marginal note and replacing it with the word "Admissions"; and

(*b*) by renumbering regulation 4 as subregulation 4(2) and inserting before subregulation 4(2) as amended the following subregulation:

" 4. (1) No person shall be admitted to the care and accommodation of a private hospital without the written consent of the person to be admitted or the written consent of his next of kin if the person to be

admitted is certified by a medical practitioner as being unfit to so consent and consent in either case shall be as in the form set out in the Second Schedule.".

Second Schedule

Regulation 8 amended

5. Regulation 8 is amended—

(*a*) by inserting after subregulation (1) the following subregulation:

" (1A) In the case of a home for the elderly, every resident shall be medically examined by a medical practitioner at least once every six months and assessed by a nurse once a month and the nursing assessments shall be entered on the Form prescribed in the Third Schedule and included in the resident's case record."; and

Third Schedule

(*b*) by inserting in subregulation (2) the words "next of kin" between the words "identification," and "complaint".

Regulation 10 amended

6. Regulation 10 is amended in subregulation (1) by deleting the words "the Schedule" and substituting the words "the First Schedule".

Regulation 20 amended

7. Regulation 20 is amended in subregulation (1) by deleting the word "four" and substituting the word "five".

Regulation 24A inserted

8. Regulation 24A is inserted after regulation 24 as follows:

"Accommodation for the elderly

24A. A private hospital licensed as a home for the elderly shall have and maintain at all times—

(*a*) a supply of wheelchairs and walkers which is adequate to render treatment to the patients; and

(*b*) other facilities as may be specified by the Minister.".

Regulation 25 amended

9. Regulation 25 is amended by inserting after the word "with" the words "and further, that a fire response exercise is carried out at least once every six months".

Schedule amended

10. The Schedule is amended by deleting the word "SCHEDULE" and substituting the words "FIRST SCHEDULE".

Second and Third Schedules inserted

11. The Second Schedule and Third Schedule are inserted after the First Schedule as follows:

"SECOND SCHEDULE

(Regulation 4(1))

CONSENT FOR ADMISSION TO PRIVATE HOSPITAL

HOSPITAL.....

*I..... hereby consent

to being admitted to the care and accommodation of the above-named private hospital.

*I..... hereby consent

to the admission of.....to the care and accommodation of the above-named hospital.

My relation to the above-named person is.....

Signature.....

Address .....

.....

Signature of Admitting Nurse .....

Date .....

*Delete whichever is inapplicable.

THIRD SCHEDULE

(Regulation 8(1A))

ASSESSMENT FORM FOR THE ELDERLY PATIENT

NAME OF FACILITY _____ DATE OF ASSESSMENT _____

SURNAME _____ FIRST NAME _____

HOME ADDRESS _____

AGE _____ SEX: Male ☐ Female ☐ RELIGION _____

MAIN DIAGNOSIS: (*at time of admission*) _____

AND OTHER MEDICAL CONDITIONS _____ _____

_____ _____

_____ _____

Activities of Daily Living	No Help Required	Some Help Required	Total Help Required
Eating/Feeding			
Toileting			
Bathing			
Dressing			

Tick Where Applicable

AMBULATION:

Does patient require assistance to move around? Yes ☐ No ☐

If yes,

Is patient bedridden? Yes ☐ No ☐

Does patient require use of a wheelchair? Yes ☐ No ☐

Does patient require use of a walker or other device? Yes ☐ No ☐

Does patient use a walking cane? Yes ☐ No ☐

ANY SPECIAL COMMENTS IN RELATION TO ABOVE:

_____

_____

_____

VITAL SIGNS: (*On Admission ONLY*)

Temperature..... Pulse..... Respiration..... Blood Pressure.....

NUTRITIONAL REGIMEN:

Diet: Normal ☐ Supplements.....

Special ☐ Appetite.....

Weight on admission:.....

Weight on:..... (*weight to be done at 1-month intervals*)

(*Date*)

STATE OF DENTITION: No teeth ☐ Own teeth ☐ Some teeth ☐ All teeth ☐

DENTURES: Upper ☐ Lower ☐ Partial ☐

SKIN INTEGRITY:

Yes ☐ No ☐

Skin intact: If no, location of Decubitus Ulcer

	Elbow	Sacrum	Shoulder	Hips	Heel	Ankle	Other (*state site*)
Odour:	☐	☐	☐	☐	☐	☐	_____
Drainage/ Sloughing	☐	☐	☐	☐	☐	☐	_____

MENTAL STATUS:

	Full Recollection	Partial Recollection	No Recollection
Memory for recent events			
Memory for long past events			
Orientation in space & time			

Tick Where Applicable

Other mental disturbances present:

Confusion	Yes ☐	No ☐
Hallucination	Yes ☐	No ☐
Depression	Yes ☐	No ☐
Aggressive behaviour	Yes ☐	No ☐
Does not groom self well	Yes ☐	No ☐

ANY ADDITIONAL COMMENTS IN RELATION TO MENTAL STATUS:

_____

_____

ELIMINATION:

Key:

Often.....*more than once a week*
Seldom.....*less than once a week*
Never.....*never or almost never*

	Never	Seldom	Often
Incontinent of Bladder			
Incontinent of Bowel			

PHYSICAL IMPAIRMENTS:

	Normal	Partial	Absent
Speech	☐	☐	☐
Hearing	☐	☐	☐
Vision	☐	☐	☐

Does the patient have amputation of any limb? Yes ☐ No ☐

If yes, where and state of stump _____

Does the patient have a prosthesis? Yes ☐ No ☐

Application of prosthesis: Self Care ☐ Total Assist ☐

Does the patient use other Assistive Devices? Yes ☐ No ☐

OBVIOUS NEUROLOGICAL DEFECTS:

Does the patient have weakness or paralysis? Yes ☐ No ☐

If yes, which side is affected? _____

Does the patient have Parkinson's Disease? Yes ☐ No ☐

Does the patient have any other neurological problem? Yes ☐ No ☐

If yes, state defects _____

_____

Does the patient receive? Physical Therapy Yes ☐ No ☐

Occupational Therapy Yes ☐ No ☐

ANY ADDITIONAL COMMENTS IN RELATION TO IMPAIRMENTS:

_____

_____

Recreational activities: Active _____ Passive Participant _____

Provision for addressing spiritual needs: _____

SKILLED NURSING NEEDS
(at time of assessment)

Parenteral meds

Inhalation Treatments

Oxygen

Suctioning

Aseptic Dressing

Lesion Irrigation

Tube Feeding

Diabetic Program: Treatment: Diet only ☐ Oral drugs ☐ Insulin ☐ Insulin & Oral drugs ☐

Blood Sugar investigations: Blood Sugar: Random _____ Fasting _____ Date _____

Urinalysis (glucose) Date _____ Time _____ Result _____

MEDICATIONS

NAMES OF DRUGS AND DOSAGE AT TIME OF ASSESSMENT

PACEMAKER: Yes ☐ No ☐ PACING RATE _____ NEXT DATE FOR REVIEW _____

ALLERGIES: _____

ACUTE ILLNESS OR INFECTION (INCLUDE DATES): _____
(treatment and progress)

HOSPITALIZATIONS: *(Date and Reason)* _____

TRANSFERS: *(Date and Reason)* _____

CLINIC VISITS _____

FAMILY VISITS _____

MEDICAL PLAN REVIEWED BY DR. ..... ON .....

NURSING PLAN REVIEWED BY R.N. ..... ON .....

SUMMARY REVIEWED BY SUPERVISOR/PATIENT CARE CO-ORDINATOR _____

NAME OF PERSON COMPLETING FORM: (*PLEASE PRINT*) _____

SIGNATURE _____

Made by the Minister this 3rd day of April, 1992.

J. ECKSTEIN
Minister of Health

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