

**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



Centre name:	Hamilton Park Care Facility
Centre ID:	OSV-0000139
Centre address:	Balrothery, Balbriggan, Co. Dublin.
Telephone number:	01 690 3190
Email address:	info@hamiltonpark.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Hamilton Park Care Centre Limited
Provider Nominee:	David Pratt
Lead inspector:	Sheila McKeivitt
Support inspector(s):	Leone Ewings, Shane Walsh (both day 1 only)
Type of inspection	Announced
Number of residents on the date of inspection:	126
Number of vacancies on the date of inspection:	3

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
29 November 2016 09:00	29 November 2016 18:00
30 November 2016 09:00	30 November 2016 14:30

The table below sets out the outcomes that were inspected against on this inspection.

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 03: Information for residents	Non Compliant - Moderate
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Major
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Substantially Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Compliant
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 14: End of Life Care	Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 17: Residents' clothing and personal property and possessions	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This inspection was announced following an application by the provider to renew the registration of 130 beds in the centre and to register for the first time five additional beds. Prior to the inspection, inspectors reviewed written evidence all documents submitted by the nominated person on behalf of the provider, for the purposes of application to register were found to be satisfactory. The Authority had been informed of a change in person in charge since the last inspection.

There were 126 residents in the centre on the day of inspection, one resident had been admitted to hospital leaving three vacant beds.

During the inspection inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

The provider and the newly appointed person in charge were found to be operating in compliance with the conditions of registration and in compliance or substantial compliance with thirteen of the eighteen outcomes inspected against. Inspectors found that the nominated person on behalf of the provider had addressed the non-compliances identified on the last inspection. The provider was working towards coming into compliance with all 18 outcomes. This was evident as since the last inspection in September 2016 when five major non-compliances were identified this had reduced to one major non-compliance and this was due to the hiring of pre-registration nurses without Garda clearance. Improvements were identified in areas including staffing, premises, risk management and governance and management.

The five outcomes not met in full on this inspection related to the safeguarding of residents', governance and management issues, health and social care needs, contracts of care and the management of complaints. The action plans at the end of this report reflect these non-compliances.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

There was a statement of purpose which described the services and facilities provided.

It had been reviewed in November 2016 and reflected the new management team. Staff were familiar with its content. A copy was on display in the main reception area and a copy had been given to each resident.

Judgment:

Compliant

Outcome 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Inspectors found some improvements had been made under this outcome. The governance and management structure had changed since the last inspection in

September 2016. A new person in charge and two new assistant directors of nursing had been appointed. New systems for monitoring the quality of care and the quality of life for residents' living in the centre had been developed and were in the initial stages of implementation.

The newly appointed management team were clear on their roles, responsibilities or/and lines of accountability. The lines of accountability for decision making and responsibility for the delivery of services to residents was now clear. The organisational structure was reflected in the statement of purpose.

The provider had made an application to renew the registration of 130 beds in the centre and register five new additional beds. These beds/bedrooms were viewed and their revised design had taken into account the revised National Standards for Residential Care Settings for Older People in Ireland 2016.

Inspectors were informed that an annual review had been completed, a copy was available for review. There was evidence that residents and their relatives had been involved in the review. They had given feedback on seven themed areas linked with the residents' quality of life in the centre. It also contained information regarding the quality and safety of care delivered to residents living in the centre. Data had been gathered about several areas of clinical care, for example, the number of falls, accidents, incidents, and use of restraint. It did not include an improvement plan for 2017.

The new management team had developed effective management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored. The management systems included an audit schedule for the remainder of 2016 and 2017. All areas of practice were covered in the plan. Inspectors found that some clinical audits on areas of practice, such as nursing documentation audit, hand hygiene practices and a medication audit had been completed. Each completed audit did not have an action plan/recommendations, therefore there was no evidence of a plan to improve the standard/quality of care in these areas of practice using the data gathered.

There was one vacant clinical nurse manager post.

The person in charge's office had been relocated from an annex room situated above the Kingfisher Unit on the first floor to the ground floor. Her office was now accessible to all residents', their families and visitors to the centre.

Judgment:

Non Compliant - Moderate

Outcome 03: Information for residents

A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:

Governance, Leadership and Management

<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: Inspectors found that there was a guide available in respect of the centre and a written contract of care in place for each resident.</p> <p>Inspectors saw a copy of the residents' guide at reception and a copy in each of the residents' bedrooms. The guide contained all the required information as per regulation 20.</p> <p>Inspectors reviewed a sample of residents' contracts of care. All those reviewed contained information relation to the care and welfare of the resident and the services provided to the residents. However, five of the 13 reviewed did not include the fee to be charged to the resident or the possible additional monthly charges that may be charged for the provision of 'additional services'.</p> <p>Each contract of care had been signed by the provider and the resident or their next of kin.</p>
<p>Judgment: Non Compliant - Moderate</p>

<p><i>Outcome 04: Suitable Person in Charge</i> <i>The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.</i></p>
<p>Theme: Governance, Leadership and Management</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: The newly appointed person in charge had not yet completed a fit persons interview to determine her fitness to be named person in charge, however, she did have the legislative requirements to be a named person in charge.</p> <p>She commenced in her role as person in charge of the centre on 01 November 2016. She submitted written evidence of her nursing experience and qualifications which assured HIQA she had 3/6 years experience of working with older people. She is contracted to work fulltime, is a registered nurse and has a Diploma in Management. Residents' spoken with were aware of the change in person in charge.</p>

Judgment:

Compliant

Outcome 05: Documentation to be kept at a designated centre

The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Inspectors found the records listed in schedules 2, 3 and 4 of the regulations were maintained in a manner to ensure completeness, accuracy and ease of retrieval.

The directory of residents contained all of the information required in schedule 3. A sample of resident's files reviewed contained all of the health and medical information as listed in schedule 3.

Inspectors reviewed the centre's operational policies. The policies were found to have been reviewed within the past six months.

Inspectors found that those read during the inspection now reflected practice. This is mentioned in more detail under the specific outcome to which the policy relates too.

All other records as per schedule 4 were maintained and readily available.

A sample of six staff files were reviewed during the inspection and were found to contain all the requirements as per schedule 2 of the regulations.

Judgment:

Compliant

Outcome 06: Absence of the Person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Governance, Leadership and Management
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: The person in charge was aware of the requirement to notify the Chief Inspector of any proposed absence for a period of more than 28 days. There were appropriate arrangements in place for the management of the centre during any such absence.</p>
<p>Judgment: Compliant</p>

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The centre had a policy on the prevention, detection and response to abuse. However, it was not implemented in practice as all reasonable measures were not taken by the provider to ensure residents' were safeguarded at all times. Five staff working with residents in the centre on the day of inspection did not have a garda vetting in place.

Inspectors spoke to a number of staff they were knowledgeable about the signs and type of abuse and knew the procedure to follow in the event that they witnessed or suspected abuse. Inspectors reviewed the staff training records and found that all staff had received up to date training around safeguarding residents.

Five pre-registration staff rostered and working with residents in the centre on the first day of this inspection were found not to have a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. The provider was requested to inform the Authority within one working day of the action they would take to address this. On the second day the provider informed the inspectors that all five staff had been given the day off. They would not have any direct contact with residents until the provider had sought a garda vetting disclosure for each of these staff. HIQA found this response provided assurances that vulnerable residents' were protected.

The centre had a policy in place on responding to residents who may display responsive behaviours. Inspectors reviewed a sample of care plans and found that they did not include details of the triggers and/or de-escalation techniques used to manage the resident displaying responsive behaviour. Where a resident was prescribed two different medications (on a p.r.n. as required basis) to manage their responsive behaviour, it was not clear which of the two medications were to be administered to the resident first. Records reviewed showed that some staff had received training in this area.

The centre's policy on use of restraint did not reflect the National policy. The centre was gradually moving towards a restraint free environment. A low number less than twenty of the 126 residents had any form of restraint in use. Inspectors saw there were several different types of alternative equipment available such as low-low beds, alarm mats and crash mattresses. The sample of restraint assessments reviewed showed that assessments did not consistently outline what if any of these had been trialled, tested and failed prior to bed rails being used as a form of restraint. The practice of requesting the residents' next of kin to consent for restraint to be used was not in line with the National policy and therefore required review.

Inspectors found that the management of residents' finances was now robust. The systems in place were now clear, concise and accurate. The centre had two policies in place to deal with resident finances. One titled "accounting and financial management" the other titled "security of residents' accounts and personal property" found that both policies reflected the current practices in place to manage resident finances.

Judgment:
Non Compliant - Major

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
This outcome was reviewed in full on the inspection in September 2016. Some of the action plans identified on this inspection were addressed.

The poor infection control practices identified during the last inspection had all been addressed :
-Basins were no longer stacked on top of each other in sluice rooms. They were seen to be stored on racks available.

- Basins were no longer stacked on the floor of communal shower rooms and ensuites. The provider had installed a stainless stain storage system for basins in each of the ensuite bathrooms.
- The rusty frames at the rear of toilets in communal shower rooms had been replaced.
- Two litre bottles of shampoo and conditioner in bathrooms were no longer stored in communal bathrooms.
- All shower trolleys and chairs in use were clean.
- Linen trolley, linen skips and incontinence wear were no longer being stored in communal shower rooms
- Clinical waste bins were now stored in the dirty utility room.

The following risks had been addressed:

- Starling Unit, bay three, room one had additional electrical sockets installed.
- Room 15 in Kingfisher had additional electrical sockets installed.
- Five litre and two litre bottles of hair conditioner and shower gel were no longer being stored in unlocked bathrooms in Starling and Nightingale -Units.

The risk associated with residents' absconding from the centre had been addressed by the installation of an electronic gate at the entrance of the driveway leading to the centre.

The records of three fire drills which had taken place since the last inspection lacked sufficient detail. They included the date, time and person leading the drill. They did not reflect attendees, response times, actions, learning/improvements required or evidence of feedback to attendees. However, it was clear from speaking with staff that they knew how to safely evacuate residents' from the centre at the time of the inspection. A fire warden was appointed on each unit on each shift and the two security men on duty at night time were also appointed fire wardens. Staff spoken with knew who the fire warden on there unit was and knew the procedure to follow in the event of the fire alarm sounding.

Judgment:
Substantially Compliant

Outcome 09: Medication Management
Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors reviewed the practices and documentation in place relating to medication management in the centre. There were written policies in place relating to the ordering,

prescribing, storing and administration of medicines to residents.

All medicines were stored securely in the centre. medicines dispensed in a monitored dosage system that consisted of individual pouches. Fridges were available for all medicines and the temperature of these fridges was monitored. All controlled (MDA) medicines were stored in secure cabinets, and registers of these medicines were maintained with the stock balances checked and signed by two nurses at the end of each working shift. There were procedures in place for the handling and disposal of unused and out of date medicines.

Inspectors reviewed the processes in place for administration of medicines, and were satisfied that nurses were knowledgeable regarding residents' individual medication requirements. Nursing staff were observed to safely administer medicines. Inspectors noted two areas of practice which required review; medications prescribed on a p.r.n. (as required basis) did not always include a maximum dose.

The planned use of a blue tray to hold pouches of residents' medication required review. This introduced an additional step in the medication administration process therefore, increased the potential risk of medication errors.

The pharmacist was facilitated to meet all necessary obligations to residents in accordance with guidance issued by the Pharmaceutical Society of Ireland, and visited the centre on a regular basis, conducting reviews of residents' medications and medication audits.

Medication incidents including medication errors were recorded and nursing staff were knowledgeable of the procedure to be followed. However, although the person in charge was monitoring medication errors there was no indication that these were reviewed to ensure that any trends could be identified and /or actions taken to prevent there reoccurrence. This finding is included under Outcome 2.

Judgment:
Substantially Compliant

Outcome 10: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
A record of all incidents occurring in the designated centre was maintained. A notification was provided to the Authority within 3 days of the occurrence of any

incident set out in paragraphs 7(1) (a) to (j) of Schedule 4, a quarterly report was provided to the authority to notify of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4. A report had been provided to the Authority at the end of each quarter.

When the cause of an unexpected death was established, the Authority was informed of that cause.

Judgment:
Compliant

Outcome 11: Health and Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:

Inspectors were satisfied residents' health care needs were met being met and residents had opportunities to participate in meaningful activities, appropriate to their interests.

Residents had access to general practitioner (GP) services and a full range of other services was available on referral including speech and language therapy (SALT), dietetic services and physiotherapy. There was a vacant occupational therapist post. Inspectors were told the post had been advertised and an interm arrangement with a private occupational therapist was being negotiated. There was a occupational therapist assistant employed in the centre fulltime. Chiropody, dental and optical services were also provided. Psychiatry for older persons services were accessible on referral.

Nursing assessments, care planning and additional clinical risk assessments were carried out for residents. Residents with identified needs had care plans in place to reflect these needs. There was evidence that residents and/or relatives were involved in the development of their care plans. Inspectors found that some care plans did not reflect the care being provided by staff, there were some gaps in there content. Residents' end of life care plans did not consistently reflect the residents' end of life wishes. Inspectors noted that care plans were not consistently updated on a four monthly basis.

Daily notes were being recorded in line with professional guidelines. The person in charge had identified gaps in nursing documentation by auditing nursing documentation since the last inspection. There was a plan in place to re-audit to determine if practice

had improved.

There was an adequate policy in place on falls prevention to guide staff. Inspectors read records of residents who had fallen and saw that risk assessments and care plans were updated post their fall. Preventative measures undertaken included the use of bed, chair alarms and hip protectors. Wound management was reviewed and found to be reflective of the centres wound management policy and reflected best practice. Also, the nutritional needs of residents were being met in a holistic manner, records reviewed reflected this.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Effective care and support

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

Inspectors reviewed the premises and saw evidence that all action plan from the last inspection had been addressed.

The four, five bedded units and one single room in Starling Unit had been reconfigured. The unit now contained 18 beds in total, 14 single and two twin rooms. All rooms contained a wash hand basin. There were three bedrooms en-suite. There were three large shower rooms in this unit. The living area was in the centre of the open plan unit. A large table ran down the middle of the unit, which all residents were seated around at 11:00hrs, as there was no separate sitting area. This refurbishment had been completed in 2015. It adhered to the national quality standards for residential care settings for older people in Ireland 2009.

The Cormorant, Kingfisher and Nightingale Unit had all been refurbished and rooms had been reconfigured. The provider had installed a new power saving low wattage lighting system throughout the centre. The corridors on each of these units had been refurbished with bright patterned wallpaper and the all seating was in the process of being recovered. Some situated in seating areas off the corridors had been re-upholstered and looked well. Each of these units now had one large open plan communal area which contained a fully fitted kitchen and dining area containing long

tables surrounded by chairs. This refurbishment did make the units more homely in appearance. The sitting area in each of these three units had been reviewed and now met the needs of residents'. The amount of communal space appeared to meet the minimum amount required per individual. There were an adequate number of assisted bathrooms to meet the needs of residents'. The oratory was accessible from the main corridor on the ground floor.

The Cormorant Unit now contained 34 single bedrooms, 29 with wash hand basins and five en-suite. Each en-suite contained a shower, toilet and wash hand basin.

The Nightingale Unit now contained 34 single bedrooms, 29 with wash hand basins and five en-suite. Each en-suite contained a shower, toilet and wash hand basin.

The Kingfisher Unit now contained 49 beds, 45 single bedrooms (12 of these shared an en-suite) and two twin bedroom all were en-suite. Each ensuite contained a shower, toilet and wash hand basin.

The issues identified on the last inspection had been addressed:

Handrails were now on both sides of the corridor in the newly refurbished Starling Unit. New handrails had been installed beside toilets, wash hand basins and shower areas in all a communal and ensuite bathrooms in each unit.

A ventilation system had been put in place in the communal bathroom (opposite bedroom 30) in Nightingale Unit.

A call bell had been put in place in communal bathroom beside room 22 in Cormorant Unit.

Room 43, a newly developed room in Kingfisher Unit had a new call bell extension installed and its ensuite had a ventilation system installed. A hand towel holder and shelve were now in place.

Room 44, a newly developed room in Kingfisher Unit had the call bell and over light bed now located at the side of the bed and in direct reach of resident. The call bell in the ensuite located beside the toilet was now long enough to reach the shower area. It had a hand towel holder, shelve or light over sink in place.

Rooms 45, 46 and 47 were all newly developed rooms in Kingfisher Unit. All now had hand rails in place, an hand towel holder, shelve and light installed over the sink.

Twin room 13 in Kingfisher Unit and both twin rooms in Starling Unit now had screens in place to ensure the privacy of residents occupying these rooms.

The bed room walls in room 12 in Kingfisher Unit had been repaired and repainted.

The ceiling and walls in bed room 13 had been repaired and repainted.

The ensuite of room 13 had a shelf for storage installed.

The walls in bedroom 16 had been repaired and repainted.

Three of single bedrooms in Kingfisher Unit had been re-constructed. They were now bright room, ensuite bedrooms.

Equipment was not seen to be stored in corridors.

The signage on assisted shower room doors had been reviewed.

A number of newly constructed ensuite doors had been painted or varnished.

Judgment:

Compliant

Outcome 13: Complaints procedures

The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There was a complaints policy in place. The process was accessible to all residents and displayed in prominent places throughout the centre. However, it did not meet the legislative requirements and the process was not effective.

The person in charge was the nominated person to deal with all complaints, the policy stated there was an appeals process however, it did not state what this process was. It did not state who was responsible for overseeing complaints and there was no evidence that they were being reviewed in line with legislative requirements.

Inspectors reviewed records of complaints and saw that only written complaints were being recorded. Two residents told inspectors they had made verbal complaints, although they were being investigated, they were not recorded. Records reviewed showed written complaints had been fully investigated with records kept of the outcome of the complaint. However, the complainants/residents level of satisfaction with the outcome was not always recorded.

Residents' had access to an independent advocate.

Judgment:

Non Compliant - Moderate

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The policies and practice in place ensured that each resident received care at the end of their life which met their physical, emotional, social, psychological and spiritual needs and respected their privacy, dignity and autonomy.

There was overnight accommodation available to the dying residents family. The centre had access to a palliative care team and there was no delay in seeking their expert advice.

As mentioned under outcome 11, all residents did not have a specific end-of-life care plan in place. Those who had end of life plans in place included details of their preferred resting place. It was evident that the resident was involved. All religious and cultural practices were facilitated by staff.

Judgment:
Compliant

Outcome 15: Food and Nutrition

Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
This outcome was not reviewed on this inspection. The provider was found to be in compliance with this outcome on the inspection in September 2016.

Judgment:
Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Inspectors found that dignity and privacy of the residents was respected by the staff. They were consulted with throughout the year about the running of the centre.

Staff were seen to be polite and courteous when interacting with the residents and the relationship between the staff and residents was seen to be warm and caring. Residents' spoken with were extremely complimentary of staff particularly the level of attention they paid to them. Residents in communal areas were supervised by staff during the inspection.

There was a visitors policy which stated there were no restrictions on visitors. This was observed as many relatives and friends visited residents' throughout the duration of the inspection. Residents' could receive visitors in private if they wished to do so.

Residents had access to a portable telephone which they were facilitated to use in private however most had their own mobile phone. Residents who wished were provided with a copy of the daily and local weekly newspapers of their preference.

Inspectors found that residents were consulted with about the running of the centre. Residents meetings took place once a month and these were chaired by a resident. Minutes were available for review and issues brought up were brought to the attention of the person in charge and a response was provided to residents at the next meeting. Residents were also consulted with by being asked to complete a questionnaire in relation to the quality of care and of service being provided to them. Contact details for the advocacy service were available within the resident's guide and the statement of purpose. The centre did not have a named advocate to date however, the new person in charge was addressing this.

Residents were facilitated to exercise their civil, political, religious rights and were enabled to make informed decisions about the management of their care through the provision of appropriate information. They had a choice to attend Mass when said in the centre. Other religious sacraments were provided to them such as holy communion and anointing of the sick.

Residents were registered to vote. A number of residents told inspectors that they had been facilitated to vote at the last election. A number of residents' informed inspectors that the centre had no internet access. The provider confirmed that this was an issue within the surrounding area and it was being addressed by the local community.

Judgment:

Compliant

***Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of***

<i>clothes to residents.</i>
<p>Theme: Person-centred care and support</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: Residents were able to maintain control over their personal property and appropriate storage facilities for their belongings were in place.</p> <p>All laundry was done in the on site laundry. Laundry was collected and returned daily by the health care assistants. All residents' clothing was labelled by the laundry staff. An inventory of each individual resident's valuables was recorded on admission.</p> <p>Residents confirmed that they had adequate storage facilities in their bedroom which included their a wardrobe, a bedside locker and a safe.</p>
<p>Judgment: Compliant</p>

<p><i>Outcome 18: Suitable Staffing</i> <i>There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.</i></p>
<p>Theme: Workforce</p>
<p>Outstanding requirement(s) from previous inspection(s): The action(s) required from the previous inspection were satisfactorily implemented.</p> <p>Findings: Inspectors saw the action plans from the last inspection had been addressed in full.</p> <p>There was currently one vacant Clinical Nurse Managers post, the vacant staff nurses had been filled the five pre-registration nurses were awaiting their registration number. These were due to come through within a two week period following this inspection. The staffing levels would then meet the needs of residents. The staffing numbers in place were now adequate to ensure the continuity of care of the current residents</p>

currently living in the centre and were now adequate to ensure the needs of 135 residents' could be met.

A record of current registration details for all nursing staff working in the centre was available for 2016. All staff had mandatory training in place including up-to-date fire training, protection of vulnerable adults against abuse and manual handling training. They had received additional training in areas such as infection control, falls prevention, medication management and cardio pulmonary resuscitation. A number of staff had attended training on caring for residents with dementia and managing residents with responsive behaviours.

Inspectors saw that the management team had completed a number of annual appraisals with staff.

Judgment:
Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Sheila McKevitt
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Hamilton Park Care Facility
Centre ID:	OSV-0000139
Date of inspection:	29/11/2016
Date of response:	20/12/2016

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The audits completed to date did not include an action plan/recommendations for improvement, identify those responsible for carrying these out and did not include a timeframe.

1. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:

Audit tools and instruments will be revised and reformatted to include action plans, recommendations for improvements, identify those responsible for actioning the recommendations and a specific timeframe for completion.

The schedule for all audits shall be reviewed and a revised audit schedule ensuring that all aspects of care and services are monitored in accordance with legislations, standards and the centre policies.

All care & services audit results, improvements recommendations and action plans shall be reviewed and discussed at the fortnightly governance management meetings.

Proposed Timescale:

New & modified audit instruments will be in use by January 30th 2017

Proposed Timescale: 30/01/2017

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The annual review did not include an improvement plan to ensure care delivered is in accordance with the relevant standards.

2. Action Required:

Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:

A full comprehensive annual review of all care and services in the Centre for 2016 is currently being undertaken. It will include all data related to 2016 (Jan – Dec). The review shall include all care and services audits that have been completed and the schedule ongoing.

The Annual Review continues to be developed taking account of the all care and services audits that have been completed and are scheduled to be completed as part of the annual review for 2016.

An improvement plan for 2017 shall be developed when the Annual Review is completed for 2016.

Proposed Timescale:

The comprehensive Annual Review Report, including an Improvement Plan for 2017,

will be fully completed by Jan 30th 2017.

Proposed Timescale: 30/01/2017

Outcome 03: Information for residents

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

All contracts of care did not include details of the fees charged to the residents'.

3. Action Required:

Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

Please state the actions you have taken or are planning to take:

All current contract have the agreed fees for cost of care. A number of contracts issued and agreed/signed do not include additional fees to be charged, as the cost of care included additional services (on admission), and in these cases no additional charges are to be applied for such services.

A full audit of all contracts of care shall be undertaken. Identified gaps shall be addressed.

Proposed Timescale: 30/01/2017

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The centres policy on use of restraint did not reflect the National policy.

The alternatives trialled, tested and failed prior to restraint being used were not consistently recorded.

The rationale for using a restraint was not always clear.

The practice of residents' next of kin consenting to a restraint being used was not in line with the national policy.

4. Action Required:

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

Please state the actions you have taken or are planning to take:

The Centre's policy on use of restraints shall be reviewed and updated to reflect the national policy on restraint use.

New documentation related to restraint use is currently being developed and shall be in line with national policy, legislation and HIQA guidelines.

Proposed Timescale: 30/01/2017

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

All staff working in the designated centre did not have a garda vetting disclosure in place.

5. Action Required:

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

Please state the actions you have taken or are planning to take:

1. The 5 pre-registered nurses as stated were removed from the roster immediately. 3 of the nurses now have Garda Vetting disclosures in place and they are currently on an induction training program where they shall continue to work under supervision. The 2 remaining pre-registered nurses are not engaged in any direct contact with residents and shall not engage directly with residents until Garda Vetting disclosures are in place.
2. All new staff joining the Centre complete Safeguarding Vulnerable People at Risk of Abuse training during their induction program.
3. A full audit of all HR files shall be conducted in January 2017 to ensure that all staff have in place a) Updated Garda Vetting Disclosure (best practice) & b) Mandatory Safeguarding Vulnerable People at Risk of Abuse training.

Proposed Timescale:

1. 30.11.16
2. Ongoing
3. 31st January 2017

Proposed Timescale: 31/01/2017

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Records of fire drills were not detailed enough. They did not reflect the names of those in attendance, details of the fire drill, findings and/or recommendations.

6. Action Required:

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:

All fire drills shall be clearly documented to include

1. Date, time and name of person leading the event.
2. Names of attendees, response time and actions taken
3. Learning from event, recommendations and feedback to inform improvements and quality

Proposed Timescale:

Immediately

Proposed Timescale: 20/12/2016

Outcome 09: Medication Management

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Medications prescribed on a p.r.n. (as required basis) did not always include a maximum dose.

The planned use of a blue tray to hold pouches of residents' medication required review.

7. Action Required:

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:

1. All Kardex (medication prescriptions) shall be audited in conjunction with the GP and the Pharmacist. Where required maximum dosage in 24-hour period shall be included. Where more than 2 medication orders are prescribed to treat a condition the

prescription shall indicate 1st & 2nd line usage

2. The use of the blue tray was introduced following a recent Medication Audit. The use of the trays shall be reviewed with the providing Pharmacy to ensure that all systems in place are robust to ensure safe administration of all medication orders.

Proposed Timescale:

1. 31st January 2017
2. 31st January 2017

Proposed Timescale: 31/01/2017

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Inspectors found that some care plans did not reflect the care being provided by staff. End of life care plans did not consistently reflect the residents' end of life wishes.

8. Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

Please state the actions you have taken or are planning to take:

1. All residents admitted to the Centre shall have a comprehensive and other required assessments as indicated completed on admission. A Care Plan shall be commenced to guide care, services and interventions, specific to identified risks based on the residents assessed functional and cognitive abilities.
2. Assessments and care plans shall be reviewed, evaluated and updated no less than every 4 months or sooner if there is a change in the resident's condition or status.
3. The auditing of Care Plans by CNMs and ADoNs shall continue to ensure they reflect and guide the care and interventions in a person centred approach. We use an online Data Care system, all staff, specifically CNMs and ADoNs shall be upskilled to utilise the systems to complete audits and ensure compliance with legislations regarding assessments, care planning and care & services delivered,
4. Training on Assessing Care of the Older Person and Person Centred Care Planning shall be scheduled and implemented by the Centre's Training and Development Officer.
5. End of Life Care Planning, to include Advance Care Directives and the implementation of the Irish Hospice Foundation "Think Ahead" program shall be included in the training schedule for 2017
6. An audit of all End of Life Care Plans and the Centre's policy Management of End of Life Care shall be conducted and an action plan to address any gaps and improvements

required shall be developed.

7. Where a residents choices not to discuss End of Life wishes, or directives this shall be respected and documented clearly in their healthcare notes.

Proposed Timescale:

1. Immediate
2. Immediate
3. 28th February 2017
4. Schedule for training to be finalised 30th December 2016
5. Schedule for training to be finalised 30th December 2016
6. 20th January 2017
7. 30th January 2017

Proposed Timescale: 28/02/2017

Theme:

Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Inspectors noted that care plans were not consistently updated on a four monthly basis.

9. Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

Please state the actions you have taken or are planning to take:

New systems have already been put in place to ensure all residents assessments and care plans are reviewed a minimum of every 4 months, or sooner where there is a change in condition or status. In the Centre we use an online Data system enabling more accurate accessible data to ensure compliance with legislative requirements and best practice in assessments and care planning.

Each unit has been assigned an ADoN to work with CNMs to ensure compliance with this legislation requirement

Proposed Timescale: 30/01/2017

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

The complaints procedure did not include information about the appeals process.

Verbal complaints were not recorded.

10. Action Required:

Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

Please state the actions you have taken or are planning to take:

The revised policy now clearly states the appeals process within the Centre.

Revised Process displayed throughout the Centre have been amended to include a guide to the appeals Process.

A named Advocate is clearly identified in the policy and on the displayed poster placed around the Centre.

All complaints including verbal complaints shall be recorded.

Proposed Timescale: 20/12/2016

Theme:

Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Records of investigated written complaints did not always reflect the outcome of the investigation and whether or not the complainant/resident was satisfied with the outcome.

11. Action Required:

Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:

The nominated person/Complaints Review Officer, shall review at the end of every month all complaints, both verbal and written.

The outcome of all complaints, including where conducted any investigations, recommendation and the complainants level of satisfaction with the outcome shall be recorded.

The complaints review officer shall analysis all complaints, identify trends and enabling corrective actions/quality improvement recommendations can be formulated and presented to the Governance Management Committee.

Proposed Timescale: 30/12/2016

Theme:

Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

A person was not nominated, to oversee all complaints, to ensure that all complaints were appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

12. Action Required:

Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

Please state the actions you have taken or are planning to take:

While there is a nominated person/ Complaints Review Officer, to oversee (review) all complaints, and to ensure that all complaints were appropriately responded to, this was not clear in policy.

The Process as displayed throughout the Centre has been amended to include the details of the Complaints Review Officer.

The Complaints Policy has been revised (see attached) and the name of the nominated person/Complaints Review Officer to oversee (review) complaints and outcomes has been included in the policy.

The Complaints Review Officer shall ensure that all complaints are overseen and reviewed in line with legislative requirements.

Proposed Timescale: 20/12/2016