

**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):	Michael Keating;
Type of inspection	Unannounced
Number of residents on the date of inspection:	114
Number of vacancies on the date of inspection:	12

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.

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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 18 December 2014 12:00 To: 18 December 2014 20:00

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

Outcome 01: Statement of Purpose
Outcome 02: Governance and Management
Outcome 04: Suitable Person in Charge
Outcome 05: Documentation to be kept at a designated centre
Outcome 06: Absence of the Person in charge
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 10: Notification of Incidents
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 15: Food and Nutrition
Outcome 18: Suitable Staffing

Summary of findings from this inspection

This monitoring inspection was unannounced and took place over the course of one day. The inspection took place in response to unsolicited information received by the Authority, the provider had submitted an application to vary conditions of registration which was also reviewed.

The Authority had been provided with information in relation to issues of concern on ten different occasions in the last quarter of 2014 and on sixteen different occasions in total since the last registration inspection on 19 November 2013, the issues of concern were in relation to premises, staffing and health care needs. These three outcomes together with nine others were reviewed on this inspection and inspectors found the centre was in compliance with two outcome's, minor non compliant with two, moderately non compliant with three and in major non compliance with the remaining five outcomes.

The management structure within the statement of purpose was not reflected in the centre and the level of services and facilities outlined in the statement of purpose were not available to residents. Inspectors found that a robust management

structure although planned was not in place and the poor management system was having a negative impact on staff, residents and relatives. This was reflected in the number of persons contacting the Authority.

The Authority had been informed of the resignation of the person in charge in October 2014 and although a new person in charge had been appointed they were not due to commence in the post until 05 January 2015. The assistant director of nursing was currently acting as person in charge, there were two vacant clinical nurse managers post and a third vacancy coming up within a week of this inspection.

Staffing levels and skill mix on the day of inspection were adequate. However, there was a consistent, high turnover of staff which was not been addressed appropriately by the management team. Staffing numbers and skill mix were not consistent and the poor management of staff rostering meant that staff were not appropriately supervised. New staff employed and working in the centre did not have Garda vetting in place and vetting forms completed by some of these staff had not been forwarded to the Garda vetting bureau. Staff files reviewed did not contain all the documents outlined in schedule two.

The premises, particularly the layout of the high dependency unit was not meeting the needs of residents. All equipment in use was not in a good state of repair and was not being serviced in a timely manner. The four newly developed bedrooms were above the minimum recommended size and appropriately laid out to meet the needs of residents'.

Inspectors found that the nursing and medical care needs of residents were been met. However, a reduction in occupational therapists working hours and a vacant psychologists post had lead to a reduction of care provided to residents by these allied health care professionals. Residents and relatives of residents in the acquired brain injury unit expressed to inspectors their request for these services to be re-instated.

Notifications had not been submitted to the Authority within three working days in response to two occasions when there had been a loss of heating in some areas of the centre.

The action plans at the end of this report reflect the outcomes not met on this inspection.

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):

No actions were required from the previous inspection.

Findings:

There was a statement of purpose available. However, it was in draft format only. The inspector was informed that it was in the process of been updated to reflect changes. It included the aims, objectives and ethos of the designated centre and a statement as to the facilities and services which were to be provided for residents.

However, it did not contain all of the information required by Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. For example, it did not reflect the current management structure or staffing numbers and skill mix currently in place. All the services and facilities described as being available to residents were not found to be available on inspection.

Judgment:

Non Compliant - Minor

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:

The governance and management structure was not sufficiently robust to ensure the delivery of safe, quality care services. This was evidenced by the number of staff, residents and relatives who had contacted the Authority within the past 13 months with issues of concern they had with the centre. A number of these persons stated that they had not brought their issues to the registered provider or person in charge as they had no confidence in them.

Inspectors found that management structure outlined on paper was not reflected in the centre. For example, the line management in the statement of purpose and the newly laminated organisation and line management structure in the centre referred to a Director of Nursing, an Assistant Director of Nursing, one Clinical Nurse Manager level 2, four Clinical Nurse Manager level 1 and a Clinical Nurse Facilitator. However, the director of nursing (person in charge had resigned, the Authority had been notified of this) and there were only two clinical nurse managers level 1 employed to work in the centre. Also the clinical nurse manager level 2 informed inspectors she had resigned and her last working day was on the 22 Dec 2014.

Inspectors were concerned that the nominated person on behalf of the provider and the acting person in charge did not have a good clear knowledge of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older Persons) Regulations 2013. This was reflected in the fact that they both told inspectors that they did not think they had to notify the Authority regarding the loss of heating which has occurred in the centre.

The clinical nurse managers spoken with told inspectors they worked as staff nurses on the floor and were not involved in the management of the centre. During the inspection, inspector's found the clinical nurse manager level 2 on kingfisher unit was the only qualified member of staff rostered to work from 17.00hrs until 20.00hrs. Inspectors were informed that a second staff nurse due to go off duty at 17.00hrs had been asked to stay on duty until 20.00hrs.

The Support Services Manager was also carrying on the role of the Accounts Manager who was on leave at the time of this inspection. Inspectors had concerns about the shared role as there was a history in the centre of mis-management of resident's funds. Although, no evidence of this was found on this inspection.

Staff spoken with were not aware of the management structure in place. They did not know the lines of Authority or accountability. Although the assistant director of nursing was acting as person in charge and was in the centre on the day of this inspection. Care staff told inspectors that they were reporting to the support services manager as she was now running the centre.

All aspects of this outcome were not reviewed on this inspection.

Judgment:

Non Compliant - Major

Outcome 04: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Governance, Leadership and Management

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

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

Findings:

The post of person in charge was vacant and had been since the end of October 2014. However, the assistant director of nursing named on the certificate of registration was deputising in her absence, the Authority had been notified of this arrangement.

Inspectors were informed that a new person in charge had been sought and was commencing full-time employment on the 05 January 2015. Inspectors were introduced to this person as they were in attendance in the centre during this unannounced inspection. However, none of the documents outlined in schedule 2 had been submitted to the Authority for this person to date.

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):

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

Findings:

Not all aspects of this outcome were reviewed during this inspection. The residents directory reviewed was completed as per regulatory requirements. A sample of resident contracts of care were reviewed and they met with regulatory requirements.

However, staff files reviewed did not meet the regulatory requirements. Four staff files reviewed did not contain all the documents as outlined in Schedule 2. As mentioned under Outcome 7 they did not contain evidence of Garda vetting and two of the four files reviewed had no written references in place although both staff were rostered to work full-time and were met on inspection.

Judgment:

Non Compliant - Major

***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

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

No actions were required from the previous inspection.

Findings:

The Chief Inspector had been notified of the recent resignation of the person in charge from the designed centre and arrangements put in place for the management of the designated centre during this post being vacant.

The assistant director of nursing was now the acting person in charge of the designated centre. She was employed full-time and had the suitable qualifications and experience to hold this post. However as mentioned under outcome 2 care staff were not aware of her role.

Judgment:

Compliant

***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):

No actions were required from the previous inspection.

Findings:

Measures to protect residents from harm and abuse were not in place. Three staff working full-time in the centre had not been Garda vetted.

Inspectors reviewed four staff files. Three of the four did not have any evidence of Garda vetting in place. Two of the staff had completed their section of the Garda vetting form, one in September and the other in October 2014. However, the completed form remained on file and had not been forwarded to the National Garda Vetting Bureau by the management team.

Inspectors reviewed the financial records of one resident and found the records of all credit and debits to the residents account were clear, concise and accurate.

Other aspects of this outcome were not reviewed on the day of inspection.

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):

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

Findings:

All aspects of this outcome were not reviewed during this inspection. Inspectors followed up on risks identified during the last registration inspection in November 2013. Inspectors found that all risks identified had been addressed. Inspectors saw that open sharp bins had been removed from resident bedrooms. All unsupervised residents' had call bells within reach. Food supplements were no longer stored in resident bedrooms, a more appropriate storage space had been sourced. Resident bedrooms and clinical equipment within these rooms were found to be clean.

Inspectors noted that the hot water from wash hand basins and shower accessible to residents in the high dependency unit was extremely hot to touch, when checked the temperature of the hot water ranged from 41 degrees centigrade to 50 degrees centigrade. This posed a risk to residents' as some temperatures measured were above the maximum temperature of 43 degrees centigrade.

Judgment:

Non Compliant - Moderate

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:

All aspects of this outcome were not reviewed. The Authority had been informed that there had been a loss of heating in part of the centre in October 2014. On inspection a member of the management team confirmed there had been a partial loss of heating in the centre on two occasions since October 2014. This partial loss of heating lasted for approximately 12 hours in total. Neither of these incidents of loss of heating had been reported to the Authority within the required timeframe of three working days.

Judgment:

Non Compliant - Major

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:

The health care needs of residents were been met in some units of the centre but were not been met in others.

Inspectors spoke with a number of residents', their relatives and reviewed a number of resident files in the high dependency and acquired brain injury units. Residents' in the high dependency unit were having their needs met. The nursing care been provided was as per the centres policy and was in line with best practice. Inspectors saw evidence on file and were informed by residents and their relatives that they were been reviewed by their medical practitioner on a frequent basis.

The nursing and medical care needs of residents in the acquired brain injury unit were met. Residents' in this unit with brain and spinal injuries were spoken with at length. They confirmed that they were consistently receiving regular input from a physiotherapy team onset. This input usually mounted to two 45 minute sessions per week. However, inspectors were informed by residents' and relatives of a lack of input from other members of the allied health care team, particularly, occupational therapists and psychologists. Residents told inspectors that they used to receive occupational therapy on a regular basis but now did not. Relatives told inspectors that there was an on site psychologist who reviewed residents on a regular basis and this service was no longer available.

On further investigation inspectors were informed that there had been a reduction in the number of hours worked by occupational therapists and the psychologist post had been vacant for a number of months. The changes to support services inputs had not been discussed with these residents' living long term in the centre and/or their relatives. Residents' told inspectors the lack of occupational therapy input was having an negative impact on their ability to becoming independent. Also, the lack of psychology input meant they had no one to talk too.

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):

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

Findings:

The premises met the needs of residents' in each unit other then the high dependency unit (Starling Unit).

The four six-bedded rooms in Starling Unit had not been re-developed to date. Residents residing here had a lack of private space available to them and therefore this unit did not meet their needs.

The Authority had been informed that equipment in use in the centre was not being serviced and some in use were in a poor state of repair. The inspector found that all equipment in use was not being serviced as per manufacturers recommendations.

Inspectors saw that hoists being used by staff had been serviced within the past year and service stickers on the relevant hoist reflected this.

However, a number of electric beds and electric pressure relieving mattresses in use on two units had not been serviced within the next service due date reflected on the relevant piece of equipment. For example, one air mattress had a service sticker on it stating next service due on 02/11/2012. There was no evidence available to determine that the service had been completed. Another service sticker on an electric bed stated last service 10/13, next service due 10/14. However there was no evidence that this service had been completed.

Inspectors saw that some equipment and furniture in use was in a poor state of repair. Staff confirmed that a shower trolley which was rusty and had a ripped covering was being used by staff to shower residents in the high dependency unit. Also, cloth covered chairs in use in some areas of the centre including the dining rooms and corridors/seating areas were badly stained, appeared dirty and in need of a deep clean.

There were no systems in place to ensure equipment in use was repaired and serviced on an ongoing consistent basis. A member of the management team confirmed this informing the inspector that a service level agreement for the servicing of equipment in 2014 had just been agreed, that is at the end of 2014.

Four new beds had been developed within the centre. Three new single bedrooms were viewed by the inspector, one contained an ensuite shower, toilet and wash hand basin the other two contained a wash hand basin. All met the minimum required measurements for a single bedroom. One was in use at the time of the inspection. However, the total occupancy of the centre remained below 126. The fourth bed proposed for registration was within a bedroom previously registered as a twin bedroom and was currently registered as a single bedroom. Although not viewed, the measurements of this bedroom and layout on plans submitted to the Authority indicated that it was large enough to facilitate two residents.

There were no thermostatic control valves or other anti-scalding protection on piped hot water supplied to wash hand basins and showers. This was evidenced by hot water being measured at above 43 degrees centigrade as mentioned under Outcome 7.

Judgment:

Non Compliant - Major

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):

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

Findings:

This outcome was reviewed in depth during the thematic inspection in July 2014. Inspectors saw that overall residents food and nutritional needs were being met. However, communication at meal time required improvement.

Inspectors saw that residents' were provided with a choice at meal times and residents confirmed this to inspectors. At lunch time, the choice of meal for residents was displayed on a notice board in each unit and included a picture of each main meal and desert available to choose from. However, the pictures on display in one unit did not correspond with the choice of food been offered and/or served to residents.

Judgment:

Non Compliant - Minor

Outcome 18: Suitable Staffing

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.

Theme:

Workforce

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

No actions were required from the previous inspection.

Findings:

The staffing numbers and skill mix was adequate to meet the needs of residents' on the day of inspection. However, this was not the case at all times. There were a number of issues in relation to staff which required review.

Inspectors spoke to a number of care staff, clinical nurse managers, staff nurses, senior health care assistants, health care assistants and interns. A number of residents and relatives on the acquired brain injury and high dependency unit were spoken to at length. Rosters on two units were reviewed in detail and staff files were reviewed.

Staff had appropriate training in place. All those spoken with confirmed that they had up-to-date mandatory training and inspectors saw written evidence that staff had completed this training. Additional training was provided to staff to ensure they could meet the needs of residents'. For example, staff had recently attended refresher training

in a local acute hospital on the re-insertion and care of percutaneous endoscopic gastric tubing.

Inspectors found that the staff roster was not well managed. The skill mix of staff allocated to work meant that staff were not carrying out their role as outlined in their job description. They were carrying out the role of others who for one reason or other were not allocated to work. For example, a clinical nurse manager (CNM) was consistently carrying out the role of a staff nurse on the unit where she worked. There was no evidence that she was undertaking any management or organisational role within the unit. On the day of inspection there was a CNM on duty from 08.00- 20.00hrs and she was the only qualified member of staff on duty from 17.00 - 20.00hrs. Inspectors observed her spending a significant period of time throughout the day administering medications to residents'.

Inspectors were informed by management that interns working in the centre were doing so under supervision and were not being counted in the staffing numbers. However, inspectors found that interns allocated to work on Starling Unit were counted in staff numbers and were not supernumerary. They were filling vacant health care assistant posts, covering sick and holiday leave. This was putting additional stress on qualified permanent care staff.

There was a large turnover of staff in the centre and this was continuing. Residents and relatives confirmed this and expressed concern about the low staff morale in the centre. Staff informed inspectors that they felt the large staff turnover was due to a recent change in staff salary, lack of support for staff from management, constant change in work practices and inconsistency of staffing levels.

Inspectors found that at weekends the number of care staff reduce by one although resident numbers remained the same. Inspectors found that that management had not put any systems in place to determine why the turnover of staff was so large and non-relenting. There were no exit interviews being conducted by management and staff informed inspectors that they did not have performance/personal development meetings completed in 2014 with their line manager and there was no evidence of these in staff files reviewed.

Judgment:

Non Compliant - Moderate

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 McKeivitt
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:	18/12/2014
Date of response:	03/03/2015

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 01: Statement of Purpose

Theme:

Governance, Leadership and Management

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

The statement of purpose did not reflect the current management structure or staffing numbers in place.

Action Required:

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of

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

Residents in Designated Centres for Older People) Regulations 2013.

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

1. Review and approve Org Structure as per agenda management meeting 21/01/15.
2. Statement of Purpose review to be completed 23/01/15.
3. Statement of Purpose to be submitted to HIQA on 23rd January 2015 by Registered Provider. 23/01/15.
4. Statement of Purpose and Organisational Structure to be communicated to all staff by installing on notice boards 23/01/15.
5. Statement of Purpose and Organisational Structure to be communicated to all staff via email, team meetings, Project Staff sessions and Q-pulse system. 3/01/15.

The organisation structure is now displayed for all staff and has been communicated through our daily meetings and formal meetings. The statement of purpose now reflects the current services and staffing levels in Hamilton Park (Completed). The Statement of Purpose has been updated in February 2015 (that is, now at revision 2) to reflect the increase in CNMs employed, and the further building work in the HDU. 03/03/15.

Proposed Timescale: 28/02/2015

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 management structure in the centre did not reflect the management structure outlined in the statement of purpose submitted as part of the application to vary a condition of registration.

Action Required:

Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

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

1. A review of the organisational structure - took place with the Director of Care, and one Assistant Director of Care (second ADOC on annual leave) and Managing Director.
2. Organisation Structure to be submitted to HIQA on 23rd January 2015 by Registered Provider.

As above in Outcome 1, the Organisational Structure was approved by Management and submitted to HIQA on 30th January as part of the Statement of Purpose. As I am now the Person in Charge, I, alongside the management team, will oversee that the

organisational chart is reflective of the current situation, and that staff are aware of their role, and to whom they report to.
If changes are to occur in the centre in future, I will, as PIC, ensure the structure and Statement of Purpose are updated to reflect the changes.03/03/15.

Proposed Timescale: 31/01/2015

Theme:

Governance, Leadership and Management

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

The management structure was not clearly defined and the lines of authority and accountability, specifies roles and details of responsibilities were not known by managers or staff.

Action Required:

Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

1. Staff Sessions have been completed on the 6th January updating staff on the Hamilton Park Quality and Safety Management System project. 35 staff members attended, where lines of reporting were presented and discussed. (Completed 06/01/15 and ongoing sessions planned as per project plan).
2. Job Descriptions have been developed and shall be approved at management team meeting on Wednesday 21st January 2015. Each job description contains detail of who the staff member is accountable to (and accountable for if applicable).
3. All job descriptions shall be distributed by the line manager to their staff/team for discussion (30/01/2015).
4. Job descriptions to be discussed, signed and agreed by all employees (20/02/2015).
5. Job Descriptions to be in staff files for each staff member (27/02/2015)
6. HCI, as part of the quality and safety management system project, to carry out further staff sessions to update staff on the management structure, lines of authority and accountability, roles and responsibilities (10/02/2015).

I can confirm that Action 1 and 2 are completed. The management structure was approved in January 2015. Education sessions on the organisational structure, and lines of authority and accountability (20 minutes each) were completed with staff on 6th January.

In addition, Staff have been educated by me, at 11 o clock meetings regarding positions and responsibilities in the organisation. I have additionally ensured that management are all aware of reporting roles and responsibilities.

In addition, A local organisational structure with pictures and names of the management team has been developed (reflecting current organisational structure).

Finally, to define each staff members lines of authority, accountability, roles and responsibility - all Job descriptions have been updated and locally approved by the

Management Team. As above, the revised target date to ensure all Job Descriptions are out with the staff members, if not already out, is the 6th March 2015.

I am overseeing the staff file update. We have designated staff members overseeing on the ground the update of staff files to meet the HIQA regulatory requirements, guided by me. These staff are working closely with me (led by Sarah Black, Administrator, who met with Shane Walsh, HIQA Inspector during the February inspection). The dedicated staff will ensure all signed job descriptions are obtained for staff files (line managers and I will oversee this).

Actions 3-6 will be completed in full by 31/03/2015 including further education sessions.
03/03/15

Proposed Timescale: 31/03/2015

Theme:

Governance, Leadership and Management

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

Management systems had not been fully developed and or implemented to ensure that the service provided was safe, appropriate, consistent and effectively monitored.

Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

1. An external company has been instated to develop, implement and audit a full quality and safety management system (in place October 2014 to September 2015).
2. Governance Policies have been approved.
3. Monthly Management Team Meetings have been scheduled to commence 21st January 2015, to continue at monthly intervals.
4. Monthly support service meetings and monthly multidisciplinary care meetings to commence and be completed following agreed terms of reference. (30/01/2015).
5. Q-pulse system training to be carried out on 15th January This will cover incidents, audits and document control.
6. HCI have an audit schedule and will ensure continuous review of processes, alongside the management team, as QIPs are developed.

I can confirm that action 1-6 above are completed.

There have been several changes to the Management Systems in Hamilton Park since the December visit, before I commenced employment. I am now the Person in Charge. We are continuing to develop a Quality and Safety Management System with the external company, which is providing strength and clarity on the day to day processes on the ground, as well as HR processes and governance processes. Audits have been ongoing to monitor care and services. Since the inspection, Hamilton Park has undergone a medication management audit, a Hand Hygiene and Infection Control Audit, and Water Temperature Audit. A care plan audit is scheduled for 4th March 2015. There is a schedule of monthly audit up to October 2015 and ongoing pharmacy audits.

We have also dedicated much time to developing CNMs on the ground. In addition we now have an 11 o clock meeting every morning where a member of staff from each unit attends a meeting to provide an update to the Director of Care. The staff are very enthusiastic about the meetings, and positive feedback has been received in relation to the improved lines of communication. The staff members then must report any updates back to their team.03/03/15.

Proposed Timescale:

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

The records outlined in Schedule 2 were not available in each of the four staff files reviewed.

Action Required:

Under Regulation 21(2) you are required to: Retain the records set out in Schedule 2 for a period of not less than 7 years after the staff member has ceased to be employed in the designated centre.

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

1. An external company has been appointed to ensure all staff are Garda vetted where this is outstanding. 28/02/15.
2. A full review of all employee files has commenced. This review shall identify any gaps as per schedule 2, and shall install a standard filing system as per agreed policy Staff Records - Content, Access and Review. Commenced and to be completed fully 28/2/15.
3. The person in charge to oversee the review of staff files and to implement the policy, to ensure staff records reflect schedule 2 requirements. 28/02/15.
4. All employee files to be relocated by the maintenance staff to the Director of Care's Office for ease of viewing and auditing. 23/01/15.

I am overseeing the staff file review and update, along with the dedicated staff members (led by Sarah Black, Administrator). All vetting forms have been sent via NHI, proof of payment was seen by Shane Lynch at the February inspection.

100% of staff files have been re-organised, indexed according to a schedule 2 based checklist, and audited against schedule 2. A full review of employee files was undertaken and completed by the 20/2/2015. The review involved actioning any outstanding items for the staff files, which had been highlighted during the audit. To address the outstanding items required for every file, a letter has been developed and provided to each Line Manager in Hamilton Park regarding overseeing obtaining the required documentation for each staff member (12/03/2015).

We endeavour to obtain items highlighted in the audit by the 12th March 2015 and we await Garda Clearing from NHI for all forms submitted. (Revised date 12/03/2015 for files and 31/03/2015 for Garda clearance forms).03/03//15

Proposed Timescale: 12/03/2015

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:

All reasonable measures had not been taken to protect residents' living in the centre as three staff employed had no garda vetting in place.

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. All staff have completed a garda vetting form (23/02/2015). All vetting forms have been sent for processing via NHI.
2. All Garda vetting forms have been sent and we are Awaiting returned forms- revised date 31/03/2015.
3. A staff record audit will be carried out the first week in March by HCI to ensure 100% compliance of garda vetting forms (booked for 04/03/2015).
4. Results to be fed back at Management Team Meetings and Project Team Meetings following audit.
5. New Employee "Packs" have been created for all newly recruited staff, which contain a Garda vetting application. Newly recruited staff shall complete and return all necessary forms prior to undertaking any residential duties (Completed, to be rolled out stating immediately).
6. Current audits undertaken will be reviewed and lessons learned, as well as actions, highlighted immediately to the team. These will continue 6 monthly, and shall only be deemed completed when I am happy with their content.

In addition, in relation to protecting residents, all staff are supervised, and I attend each unit at various times on a daily basis, as does the Acting Assistant Director of Care. In addition, as referred to above we have provided support and training to CNMs to ensure they are able to Supervise at local level appropriately.

In addition, The HR Recruitment Policy has been updated since the HIQA visit in December, to ensure all staff employed have the required and suitable skill mix and qualifications to work in their role effectively, ensuring safe and high quality services are provided. 03/03/15.

Proposed Timescale: 04/03/2015

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:

The high temperature of the hot water posed a potential risk to residents'.

Action Required:

Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

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

1. As a primary control measure, An emergency action plan has been commenced to install over 90 thermostats. There will be a thermostat installed to every sink within the organisation to ensure that the temperature remains within acceptable limits (30/01/15).
2. As a secondary control measure, a thermostat has been installed for the boiler. (30/01/15).
3. An audit of hot water temperature in resident areas will be carried out by HCI on 04/01/15).
4. The audits will continue on a monthly basis thereafter by the support services manager.
5. Results will be reported back at the following management and project team meetings.

The above actions have been completed. I am confident, via linking closely with Thomas Walsh, Maintenance Manager regarding daily audits, and via completion of audit carried out by the external company in February, that the thermostats are managing the risk and ensuring that water is under 43 degrees as per HIQA standards. 03/03/15.

Proposed Timescale: 30/01/2015

Theme:

Safe care and support

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

There was no system in place to randomly check the temperature of the hot water on a regular, consistent basis to ensure early detection of the potential risk to residents'.

Action Required:

Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

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

- 1.As a primary control measure, An emergency action plan has been commenced to install over 90 thermostats. There will be a thermostat installed to every sink within the organisation to ensure that the temperature remains within acceptable limits (30/01/15).
- 2.As a secondary control measure, a thermostat has been installed for the boiler. (30/01/15).
- 3.An audit of hot water temperature in resident areas will be carried out by HCI on

04/01/15.

4. These audits will continue on a monthly basis by the support services manager
5. Results will be reported back at the following management and project team meetings.

All the actions have been completed and the Maintenance Department now carry out a daily audit of water temperatures, and link with me on the audit findings daily (initiated on 16/02/2015).03/03/15.

Proposed Timescale: 16/02/2015

Outcome 10: Notification of Incidents

Theme:

Safe care and support

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

There had been a partial loss of heating on two separate occasions since October 2014. Neither had been reported to the Authority as required within 3 working days.

Action Required:

Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

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

As Person in Charge since February 2015, I am aware of the requirements regarding Notifiable Events. We also have a policy in place as part of our Governance and Management Policies, which describes internal and External Communication Requirements, including Notifiable Events to HIQA. I am aware that it would be unacceptable to not report a loss of heating to HIQA within 3 days. Such an event will not happen again. 03/03/15.

Proposed Timescale: 03/03/2015

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:

Residents' allied health care needs are only being partially met.

Action Required:

Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

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

1. Since commencing work at Hamilton Park, I am aware that the occupational therapist is employed and has been, full time at. The previous OT resigned to further her studies and in regard to the new full time OT, I am confident from overseeing her work and spending time with her, that the residents care needs are being met in relation to occupational therapy. However as part of my role as PIC, I will continue to work with the new OT to ensure the needs of the residents and will make recommendations to the Managing Director where any concerns may arise. (completed)

2. All residents can be referred to a psychology service as their needs identify. This service is available. (completed)

3. In relation to the Activity Coordinator, we are going forward with the intention of having an Activity Coordinator who oversees and coordinates the activity team. The job description and individual have been identified for the role. (to be confirmed by 31/03/2015).

Proposed Timescale: 31/03/2015

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

All equipment was not in good working order. A shower trolley in use was in a poor state of repair.

Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

All shower trolleys will be repaired and upgraded to incorporate features such as extra rails following staff feedback (30/01/15).

I can confirm that two new shower trolleys have been purchased, and are being used by staff. The current shower trolleys have been sent for repair. I will ensure that all equipment is in excellent working order as part of my role as PIC, via on the ground daily checks and linking with Thomas Walsh, Maintenance Manager. 03/03/15.

Proposed Timescale: 30/01/2015

Theme:

Effective care and support

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

All equipment was not in good working order. Some cloth covered chairs were heavily stained and appeared unclean.

Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

A schedule of chair replacement has been implemented. A number of chairs have gone for re-covering. This aims to be completed in 6-8 weeks. (13/03/15).

New chairs have been ordered for the facility, and other chairs have been sent for re-covering. As Person in Charge, I will oversee that no chairs will be heavily stained or of unclean appearance, in conjunction with the Services Manager, to ensure hygiene and infection prevention control as well as respecting all residents dignity. 03/03/15.

Proposed Timescale: 13/03/2015

Theme:

Effective care and support

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

Equipment in use was not serviced. Air mattresses were not been serviced on an annual basis as per manufacturers recommendations.

Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

1. All mattresses had been serviced annually, please see service report completed.
2. Going forward, as of 5th January 2015, all mattress within Hamilton Park are to have the record of Service attached 30/1/15.

I will oversee as part of my current role as PIC that equipment is serviced appropriately and that in addition, the servicing of all equipment including air mattresses is evident on each item (that is, specifically, attached to each air mattress). (Was Completed 31/01/2015). 03/03/15.

Proposed Timescale: 30/01/2015

Theme:

Effective care and support

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

Equipment in use was not serviced. Electric beds were not been serviced on an annual basis as per manufacturers recommendations.

Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the

designated centre.

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

1. All electric beds had been serviced annually, please see service report.
2. Going forward, as of 5th January 2015, all beds within Hamilton Park are to have the record of Service attached.
3. A register record is to be maintained to ensure accessible information is available to all staff and visitors to show upon request.

This is now under my duties as, and I will oversee that equipment is serviced appropriately and that in addition, the servicing of all equipment including is evident on each item (this was completed 31/01/2015). 03/03/15.

Proposed Timescale: 20/02/2015

Theme:

Effective care and support

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

Hot water taps did not have thermostatic controlled valves incorporated or an suitable anti-scalding protection device.

Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

1. As a primary control measure, An emergency action plan has been commenced to install over 90 thermostats. There will be a thermostat installed to every sink within the organisation to ensure that the temperature remains within acceptable limits (30/01/15).
2. As a secondary control measure, a thermostat has been installed for the boiler.30/01/15.
3. An audit of hot water temperature in resident areas will be carried out by HCI on 04/01/15.
4. These audits will continue on a monthly basis by the support services manager. ongoing.
5. Results will be reported back at the following management and project team meetings. 05/03/15.

The checks of temperature have been changed to daily checks. As PIC, I will continue to oversee this action on an ongoing basis. Daily checks will continue also. 03/03/15.

Proposed Timescale: 05/03/2015

Theme:

Effective care and support

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

the following respect:

The high dependency unit (Starling Unit) is not appropriately laid out to meet the needs of residents'.

Action Required:

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

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

1. Plans have been submitted to show the changes to the HDU. A 6 bedded unit is currently being changed to a 5 bedded unit, 30/01/15.
2. SOP being updated to reflect the number of beds being less and the outlay of the newly designed unit,23/01/15.

In January 2015, David Pratt, Registered Provider, and Thomas Walsh, Maintenance Manager successfully oversaw the construction of one unit (wing) of the HSU from a 6 bed room, to three individual single rooms, one double room, and a store room. Currently, a second wing of the unit is under construction to be developed into the same breakdown of 3 single and 1 double rooms. We have received excellent feedback on the new units, and I am confident that this is a move towards achieving appropriate layout for the residents. All renovations are compliant with regulations.03/03/15.

Proposed Timescale: 13/03/2015

Outcome 15: Food and Nutrition**Theme:**

Person-centred care and support

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

The choice of food offered & available to residents at lunch time did not correspond with the pictorial choices on display on the notice board in dining room.

Action Required:

Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

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

This now falls under my duty as PIC. The plan is to educate staff that the pictures on the communications board for residents show a true reflection of the menu of that day. Our PR staff member has started to develop new pictorial displays for all units. Staff have been made aware to flag any missing pictures immediately to the PR staff and Chef via the 11 o clock meeting or via their line manager.

Proposed Timescale: 12/03/2015

Outcome 18: Suitable Staffing**Theme:**

Workforce

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

Staff rostered to work on each unit were prevented from carrying out their role as per their job description due to the poor management of staff rosters and allocation of staff by senior management.

Action Required:

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

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

1. There is a new CNM appointed for Kingfisher Unit with only one vacancy for Nightingale. This position has been advertised both internally and externally and we hope to have internal applications. Interviews will be followed up accordingly and as soon as possible. 30/01/15.
2. A full review of staffing has been carried out and submitted to HIQA previously. This exercise of reviewing the units staffing levels will be repeated within the next week to ensure dependency levels are reflected in the staffing rosters. 23/01/15.
3. Sickness management training, appraisal training and staffing levels training will be provided to all CNM's once the recruitment for nightingale has been completed.28/02/15.

These actions have been completed and the CNMs have a minimum of 4 hours per week additional management time. There is now a fifth CNM for Linnet Unit – 5 CNMs total. The CNMs are now responsible for rostering for their unit, with support from myself, and this is working out very well.03/03/15.

Proposed Timescale: 03/03/2015

Theme:

Workforce

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

The numbers and skill mix of staff were not appropriate to meet resident needs at all times as they were not consistent numbers and skill mix on duty each day 7 days a week.

Action Required:

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

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

1. There is a new CNM appointed for Kingfisher Unit with only one vacancy for Nightingale. This position has been advertised both internally and externally and we hope to have internal applications. Interviews will be followed up accordingly and as

soon as possible. 30/01/15.

2. A full review of staffing has been carried out and submitted to HIQA previously. This exercise of reviewing the units staffing levels will be repeated within the next week to ensure dependency levels are reflected in the staffing rosters. 23/01/15.

3. Sickness management training, appraisal training and staffing levels training will be provided to all CNM's once the recruitment for nightingale has been completed. 28/02/15.

These actions have been completed and the CNMs have a minimum of 4 hours per week additional management time. There is now a fifth CNM for Linnet Unit – 5 CNMs total. The CNMs are now responsible for rostering for their unit, with support from myself, and this is working out very well. 03/03/2015.

Proposed Timescale: 03/03/2015

Theme:

Workforce

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

Measures had not been put in place to determine the root cause analysis of the large consistent, unrelenting turnover of staff.

Action Required:

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

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

1. All staff will be surveyed to provide a guide to management team of some of the issues affecting the retention of staff.(to be sent out with February payslips) 28/02/15.
2. All staff exiting Hamilton Park will be offered an exit interview by another member of the management team. Ongoing.
3. All staff pay levels have been brought in line with fairness to avoid discrepancies in pay under the same role and responsibilities. Completed.
4. Multidisciplinary team meetings have commenced monthly to enable all staff to participate and enable positive changes to be made through the governance structures now put in place. Terms of reference have been approved. 27/02/15.
5. Unit meetings have commenced- sample template agenda given to the CNM's to guide them in their staff unit meetings.23/01/15.
6. We are starting the appraisal program from March. Commenced and ongoing.

Proposed Timescale: 28/02/2015

Theme:

Workforce

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

Staff are not appropriately supervised. Interns are not supernumerary they are covering vacant staff posts.

Action Required:

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

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

1. Interns are not to be counted in the numbers. Any member of staff that is sick and unable to come to work is replaced by another member of staff at the same grade and with the same role and responsibility. We make every effort to cover all sickness absences and do not condone interns being counted in the staffing numbers even if they do possess Fetec Level 5. This will be highlighted and reinforced to staff at the management team meetings and the CNM meetings being arranged by the new PIC. 30/01/15.
2. Once the current number of interns have completed their contract, no new contract have been agreed nor will be, until such a time that is deemed appropriate through the new management structures and the governance structures that have been put in place. This will ensure that all interns in the future if any, will receive the appropriate level of supervision. Completed.

As PIC I can clarify that from January 2015 onwards Interns are not considered in the roster and always work Supernumerary. Interns are closely supervised by the Nurse in Charge and CNM. Interns, where they have completed their placements successfully, shall be where possible and a vacancy exists, considered for employment by Hamilton Park. 03/03//15.

Proposed Timescale: 30/01/2015**Theme:**

Workforce

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

Permanent staff did not have performance or personal development meetings completed with their line manager on a regular consistent basis.

Action Required:

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

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

1. As part of the Quality and Safety Management System, the stage concerning Human Resources has been completed by the 5th January. Going forward, CNM's will be trained in the appraisal process and the schedule of staff development along with the support of the clinical Nurse Facilitator and the Nursing Management team. 27/02/15.
2. Once line managers have been trained, all staff will receive a one-to-one meeting with their manager to do a review of their role, responsibilities, how it is carried out and a development plan will be agreed at this meeting. Commenced by 02/03/15.

Actions regarding HR have been completed (only items remaining are any outstanding job descriptions as above). The CNMs received dedicated training including performance

appraisal and personal development from the external company on 20th February 2015.
The one to one meetings are on target, and ongoing. 03/03/15.

Proposed Timescale: 02/03/2015