Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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 McKevitt
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	127
Number of vacancies on the date of inspection:	1

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 following an application to vary registration conditions. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
07 September 2016 09:30	07 September 2016 20:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Substantially Compliant
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 04: Suitable Person in Charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Major
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 12: Safe and Suitable Premises	Non Compliant - Major
Outcome 15: Food and Nutrition	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Major

Summary of findings from this inspection

This announced inspection was scheduled in response to an application made by the provider to vary condition seven of the certificate of registration. It requested to change the maximum number of residents from 130 to 135. This application was received on 20 July 2016. Additional supporting documents were submitted in August 2016. The inspector also followed up on the six outcomes which were non compliant on the last inspection completed in February 2015. The action plans in relation to four of these outcomes had been addressed. However, actions in under two outcomes governance and management and staffing had not been addressed.

The inspector was provided with an updated statement of purpose. However, it did not accurately reflect the services and facilities available to residents'.

A significant amount of internal refurbishment had been completed in the centre. This included an updated closed circuit television (CCTV) system, new emergency lighting system, magnetic devices on all doors attached to fire alarm system, new internal lighting and reconfiguration and refurbishment of communal spaces and corridors on each unit. However, the inspector found that new bedrooms and bathrooms had not been completed in line with the standards. There were additional items excluded such as privacy screening in twin rooms and handrails in circulation

areas.

The governance and management team in the centre was not strong. There was a conflict of roles and responsibilities and accountability within the management team. An annual review had not been completed in February 2015 and still had not been completed on this inspection. The systems in place for reviewing practices was not detailed enough to assess, evaluate and improve the provision of services in a systematic way to achieve the best outcomes for residents .

The practices in place to management residents' finances were not robust. Records kept were not clear. Residents' money was not individualized. None of the practices reflected the policies in place. There were no records to reflect when the new emergency lighting system was installed and when it was last tested. Fire drills had not been practiced with staff since October 2015.

The risk register did not reflect the risks identified on this inspection and the inspector raised concerns that one major risk of residents' absconding from the centre had not been risk assessed and was not satisfied that the measures put in place were adequate to prevent a major incident.

All staff had not had appraisals since the last inspection in February 2015 although this was an action plan on the report. The numbers of staff nurses employed in the centre was not adequate to provide continuity of care to the 129 residents' currently living in the centre. Two of whom were in hospital on the day of this inspection. Agency staff were covering up to three of the five night staff nurses required to care for residents on night duty.

The inspector informed the provider, person in charge and assistant director of nursing of these findings at the end of the inspection. They were informed that the application to vary was not going to be recommended due to the level of non compliances.

The provider, person in charge and assistant director of nursing were requested to attend a meeting in the Dublin office on 12 September 2016 to discuss the findings on this inspection.

The action plans at the end of this report reflect the level of 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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The following action plan from inspection which took place in February 2015 had not been addressed;
The statement of purpose did not include all the information outlined in schedule 1.

A statement of purpose to reflect the application to vary was not submitted with the application. A revised statement of purpose dated 05 September 2016 was given to the inspector at the commencement of this inspection. It included a statement of the aims, objectives, ethos and core values of the designated centre. It did not accurately reflect the information outlined in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. For example, page 2 stated there were 135 beds in the centre, page 10 stated there were 128 single bedrooms and 4 twin reflecting 136 beds. Page 18, states that all fire systems are checked annually at minimum, this does not reflect the regulatory requirement. Page 9 stated that there is a wonderful country view or paved courtyard view from every window however as evidenced under outcome 12 this is not factual.

Judgment:
Substantially 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:
The following action plan from inspection which took place on 02 February 2015 had not been addressed;
There was no annual review of the quality and safety of care delivered to residents.

The inspector was informed that an annual review had not been completed. This was a re-occurring non compliance. No annual review had been completed in this centre to date. Minutes of the eight monthly management team meetings conducted in 2016 were reviewed. These were attended by the provider, person in charge and assistant director of nursing. The annual review was not referred to in any of these monthly management meetings.

The management team were not clear on their roles, responsibilities or/and lines of accountability. It showed that all staff reported to the person in charge who in turn reported to the provider. However, some staff told the inspector they reported directly to the provider. The lines of accountability for decision making and responsibility for the delivery of services to residents was not clear.

An application to vary condition 7 of the certificate of registration was received by Hiqa on 20 July 2016. This request was to increase the maximum bed numbers in the centre from 130 to 135. An updated statement of purpose, the required application fee and two copies of the final floor plans were not submitted as required with the application to vary. The registration office sent a letter to the provider requesting this outstanding information on 25 July 2016. All the requested information was received on or prior to the 11 August 2016. However, the statement of purpose submitted did not reflect the application to vary, it was dated 04 July 2015. The inspector requested an updated statement of purpose on 05 September 2016. This was reviewed on inspection and as reflected under outcome 1 it did not reflect the required details required under schedule 1 of the health act.

There was no evidence that when designing and commissioning the new bedrooms that the provider had taken into account the revised National Standards for Residential Care Settings for Older People in Ireland 2016. Residents now occupied these bedrooms.The failings are detailed under outcome 12.

Effective management systems were not in place to ensure that the service provided was safe, appropriate, consistent and effectively monitored.

There was no evidence that serious incidents which occurred in the centre were being discussed at these meetings. For example, in January 2016 the unexplained absence of a resident was reported to the Authority. There was no evidence that this incident had been discussed and measures put in place to address the risk of a reoccurrence. Minutes of meetings held in June and July 2016 referred to new close circuit televisions cameras

(CCTV) being installed. However, in mid August 2016 there was another incident of the unexplained absence of a resident. The inspector saw that new CCTV cameras had been installed. However, It was not clear if these were installed before or after this incident occurring in August 2016. This risk was not entered in the risk register. The inspector found that the electronic gate at the top of the drive was left open at all times.

Clinical audits on areas of practice, such as physical restraint use, nursing documentation audit, diabetes care audit and medication audit had been completed by the management team in 2016. Each completed audit had an action plan and there was evidence that the person in charge had addressed these actions as they were all signed off and dated. However, the areas of practice mentioned above had not been re-audited therefore, there was no evidence if the standards/quality of care in these areas of practice had improved.

There was one vacant clinical nurse manger post.

The person in charges office had been relocated to an annex room situated above the Nightingale Unit on the first floor. One had to climb up approximately 10 steps to access this office, therefore it was inaccessible to large number of current residents' and their relatives.

The major non compliances detailed in outcomes 2, 7, 8,12 and 18 on this inspection and a recurrence of major non compliance in outcome 2, 12 and 18 evidence that the governance and management of the centre requires significant and sustained improvement.

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):
No actions were required from the previous inspection.

Findings:
There was a person in charge of the designated centre. She had commenced full time in the post on 09 February 2015. as identified in the last inspection report she had the required qualifications and experienced necessary to manage the centre including the minimum of three years experience in the area of nursing of the older person within the previous six years. She worked fulltime.
and had sufficient clinical knowledge and adequate knowledge of the legislation and her statutory responsibilities.

to be engaged in the governance, operational management and administration of the centre.

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:
The inspector found that the management of residents' finances was not robust. The systems in place were not clear, concise and some reviewed were not 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" both effective from 03/05 2016. However, the inspector found that neither of these policies reflected the current practices in place to manage resident finances. This was identified as a major issue in this centre in 2013 when financial regularities were identified. These regularities were subsequently addressed by the provide at that time.

The inspector was informed that the provider was a pension agent for 23 residents. The general accounts and administration manager managed these accounts and described the system in place to the inspector. All residents had an individual code and this code was used to identify the individualised monies withdrawn and lodged to the one bank account used to lodge residents' monies into. The inspector was informed that the resident or their next of kin (with the resident's permission) could be given a detail account of all their personal transactions over a period of time by entering their individualised code. Residents' did not have individualised bank accounts. None of this practice was reflected in the policies reviewed. This practice did not reflect that outlined in standard 3.6 of the national standards of residential care settings for older people in Ireland 2016 issued on 01 July 2016.

The centre managed petty cash for a large number of residents'. The inspector was informed that petty cash was kept in a safe and the receptionist staff had responsibility for providing this to residents' on request. The process described to the inspector was that all transactions in and out were signed by two staff or a staff member and the resident, this transaction was then entered in the residents individualised computer based account petty cash record where the running total of the resident petty cash was recorded. The inspector could not determine if this recorded total was the actual amount

held on behalf of the resident as all the resident petty cash was held together only their receipts were held in individualised plastic pockets. None of this practice was reflected in the policies reviewed. This practice did not reflect standard 3.6 of the national standards of residential care settings for older people in Ireland 2016 issued on 01 July 2016. The procedures described did not reflect HIQA's Guidance for Designated Centres, Residents' Finances launched in October 2014.

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:
The following action plan from inspection which took place in February 2015 had been addressed;
There are no records of monthly water temperature audits that were due to have begun on 4 January 2015.
There were no soap dispensers or hand drying facilities above wash hand basins in the newly renovated wing of Starling Unit.
Two fire exits in the centre were blocked by furniture.

The inspector reviewed records of daily temperature checks conducted in a random sample of 2 areas f the centre each day. Bedrooms checked had temperatures of greater than 18 degrees recorded and corridors had temperatures of greater than 21 degrees recorded.

There were soap dispensers and hand drying facilities above each wash hand basin in resident bedrooms with a wash hand basin and in bathrooms and toilets viewed in Starling Unit.

All fire exits in the centre were clear. All four units inclusive of corridors were checked by the inspector throughout the course of the day.

There was evidence that all staff had attended fire training with an external training provider within the past year. All internal doors had been fitted with a magnetic device which was linked to the fire alarm system. This enabled them to close automatically in the event of the fire alarm sounding. The inspector was informed that emergency lighting had been replaced in each room and over each fire exit door. The inspector requested records to evidence that fire equipment had been serviced in accordance with regulatory requirements. Records were provided to show that all fire extinguishers within the designated centre had been checked by qualified personnel within the last

year. The date 08/2016was the date that all were serviced. This was recorded on a random number of fire extinguishers checked by the inspector. Records to reflect the dates the fire alarm and emergency lighting had been serviced by qualified personnel since the last inspection were not available in the centre. The inspector was informed that they could not be located. Records to reflect that the fire alarm had been serviced on a quarterly basis since February were emailed to the inspector within 24 hrs of completion of the inspection.

Records showed that three fire drills had taken place in 2015, 1 in April, 1 in September and 1 in October. However, there was no evidence to show that a fire drill had been practiced with staff since October 2015. The records of the fire drills which had taken place in 2015 were vague, 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. Therefore, it was not clear if staff knew how to safely evacuate residents' from the centre. The person in charge told the inspector that she and a number of staff had recently completed fire warden training and that staff were in the process of being appointed as fire wardens including the two security men on duty at night time. A fire warden would be appointed on each unit at the beginning of each shift. However, this process was not implemented to date.

Wash hand basins with hand drying facilities and soap dispensers were available in all ensuites and in those bedrooms which did not have ensuites. Hand sanitizers were available throughout corridors of the designated centre.
However, the inspector observed the following poor infection control practices when walking through the centre with the provider:
-Basins stacked on top of each other in sluice rooms in Starling, Nightingale and Cormorant Unit.
-Basins been stored and stacked on the floor of communal shower rooms and resident ensuites.
-Rust on frame at rear of toilets in communal shower rooms, area could not be cleaned thoroughly due to rust.
-Two litre bottles of shampoo and conditioner in bathrooms used for communal use.
-Shower trolley and shower chair were being used in an unclean state in a communal shower room.
-Linen trolley, linen skips and incontinence wear being stored in communal shower rooms and
-Clinical waste bin being stored in communal bathroom.

The following risks were identified:
-Starling Unit, bay three, room one had a two point extension lead in use at outer side of top of bed. This was a trip hazard.
-Room 15 in Kingfisher had an extension lead in use at outer side of top of bed. This was a trip hazard.
-Five litre and two litre bottles of hair conditioner and shower gel being stored in unlocked bathrooms in Starling and Nightingale -Units. These risks together with the risk of a resident absconding from the resident were not included in the risk register.

Judgment:
Non Compliant - Major

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):
No actions were required from the previous inspection.

Findings:
The inspector was informed that major refurbishment work had been completed on both Starling and Nightingale Units. Some newly developed bedrooms were occupied by residents'. The provider was adhering to condition seven of the certificate of registration and had not gone above the maximum number of residents' which was 130. Five vacant rooms were identified. However, one was deemed unsuitable for a resident to reside in.

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 no 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. The oratory was situated in this unit. Residents, staff and relatives from other units had to walk through this area in order to access the oratory from within the centre. 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. However, at 11:00hrs a number of residents' were seen placed sitting at these tables although not dining. The sitting area in each of these three units was located in an area off the corridor opposite these open plan areas. These sitting areas did not appear to be large enough to accommodate all residents' in a comfortable relaxing manner. The amount of communal space appeared to meet the minimum amount required per individual however, its layout required review to ensure the communal spaces were meeting the needs of residents.There were an adequate number

of assisted bathrooms to meet the needs of residents'.

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 48 beds, 46 single bedrooms (12 of these shared an en-suite) and one twin bedroom all were en-suite. Each ensuite contained a shower, toilet and wash hand basin.

In total the inspector identified 134 bedrooms fit for purpose and not 135 identified on the application to vary.

The following issues were identified by the inspector while inspecting each unit with the provider;
No handrails on any of the corridors in the newly refurbished Starling Unit.
No handrails beside toilet or beside shower area in a communal bathroom in Nightingale Unit.
No ventilation system or window in communal bathroom (opposite bedroom 30) in Nightingale Unit.
No call bell in communal bathroom beside room 22 in Cormorant Unit.
In the ensuite in room 16 and in the assisted shower (with ceiling hoist) both in Cormorant Unit had no handrails in place.
Room 43, a newly developed room in Kingfisher Unit had no call bell extension and its ensuite had no ventilation system or window in place and had no hand towel holder or shelve in place.
Room 44, a newly developed room in Kingfisher Unit had the call bell and over light bed located at the side of the bed and therefore not in direct reach of resident. The call bell in the ensuite located beside the toilet was not long enough to reach the shower area. It had no had no hand rails in place, no hand towel holder, shelve or light over sink in place.
Rooms 45, 46 and 47 were all newly developed rooms in Kingfisher Unit. The ensuite in each of these rooms had no hand rails in place, no hand towel holder, shelve or light over the sink.
The ensuite in room 4 in Kingfisher had no handrails in the shower area.
Twin room 13 in Kingfisher Unit and both twin rooms in Starling Unit did not have screens in place to ensure the privacy of residents occupying these rooms.
The bed room walls in room 12 in Kingfisher Unit required repair.
The ceiling in bed room 13 was badly stained and required repair. The walls in this room were damaged and required repair.
The ensuite of room 13 had no shelf for storage, toiletries were stored on top of the toilet.
The walls in bedroom 16 had plaster patched and these areas had not been repainted.
The windows in a number of single bedrooms in Kingfisher Unit were small and faced onto a grey outside wall. Therefore, these bedrooms were dark as little daylight was filtered into the rooms.
Equipment such as hoists were stored in the corridors in 2 units.

The signage on assisted shower room doors read toilet. Signage required review.
A number of newly constructed ensuite doors had not been painted or varnished prior to installation.

It was evident that the newly developed rooms had not been inspected by the management team and not cross referenced against the National Standards of Residential Care Settings for Older Persons in Ireland 2016 prior to the application to vary being submitted to HIQA.

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

Findings:
The following action plan from inspection which took place in February 2015 had been addressed;
The choice food that was on offer to the residents was not correctly displayed in two units and thus limited communication of options to residents.

The inspector observed residents on two of the four units being served lunch during the inspection. Residents' could see the choice of meal on offer as it was being served by a catering assistant from a heated food trolley. The inspector met the chef on duty and was informed that there was a three week menu cycle which was in the process of being reviewed by the chef and dietician. In the kitchen the chef held a list of residents names, their preferred foods, the consistency of diets prescribed for them and it identified those on special diets. This list was updated monthly by nursing staff or when there was a change in the residents' admitted or ones status. The chef explained how he and his team and had set an agenda for an upcoming meeting he had planned with the dietician.

Judgment:
Compliant

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

Findings:
The following action plan from inspection which took place in February 2015 had not been addressed:
Permanent staff did not have performance or personal development meetings completed with their line manager on a regular consistent basis.

The inspector reviewed a sample of five staff files, four contained all the required documents, one file of a recently employed staff member contained no references. Only one of four staff who had been employed in the centre for a period of time had a staff appraisal completed. The inspector was informed that these had been commenced however, those completed amounted to approximately 50 of the 176 staff employed in the centre.

There were currently one vacant Clinical Nurse Managers post, four vacant staff nurses posts and an additional two staff nurses on leave. Agency staff were being employed to fill the vacant shifts on the roster. However, the person in charge told the inspector that vacant day shifts were not been filled. Therefore, on seven out of fourteen day roster there was one staff nurse (and seven health care assistants) on day duty caring for 34 residents. On this same unit there was one staff nurse allocated at night. Five of the fourteen nights on the current roster were covered by agency staff.

On review of the two week night roster for each of the four units there were five staff nurses allocated to work. Out of the 70 night shifts, 30 were being covered by agency staff. There were not enough nurses employed in the centre. The management team were aware of this and had five nurses recruited and due to start adaptation in September, October and November 2016. Currently they do not have an adequate number of staff nurses employed in the centre to provide continuity of care to the 129 residents' living there. The inspector therefore could not propose registration of an additional beds as per the application made to vary condition 7.

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 and cardio pulmonary resuscitation. Staff nurses had received training in medication

management. The inspector was informed that a number of staff had been booked into external training on caring for residents' with dementia and managing residents' with responsive behaviours.

The inspector was informed that there was just one volunteer working in the centre. The inspector saw that this volunteer had gone through the garda vetting process and had roles and responsibilities in place. A sample of five staff files were reviewed four of the five contained all the required information as outlined in schedule 2. However, one file reviewed did not include any references for the employee.

Judgment:
Non Compliant - Major

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:

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Inspector of Social Services
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Health Information and Quality Authority
Regulation Directorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	Hamilton Park Care Facility
Centre ID:	OSV-0000139
Date of inspection:	07/09/2016
Date of response:	27/09/2016

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 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 include all the information outlined in schedule 1.

1. 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 Residents in Designated Centres for Older People) Regulations 2013.

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

Please state the actions you have taken or are planning to take:
Action Taken
A revised Statement of Purpose is available (see attached Appendix 1)

Person Responsible
Registered Provider

Proposed Timescale: 26/09/2016

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 documents required to support an application to vary were not submitted together with the application on 20 July 2016.

2. Action Required:
Under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 you are required to: Provide all documentation prescribed under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015.

Please state the actions you have taken or are planning to take:
This application has been withdrawn.

Person Responsible
Registered Provider

Proposed Timescale: 27/09/2016

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management team are not clear on their roles, responsibilities or/and lines of accountability.

3. 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:
The current Management and Governance structure shall be reviewed. All members of the Management Team shall be clear of their roles, responsibilities and lines of accountability

In 2015 new structure and systems were developed and implemented.
A review of the effectiveness of these systems shall be completed by the Management Team, directly overseen by the Registered Provider and the Person in Charge

Polices shall be reviewed and updated to reflect and guide the roles, responsibility and accountability of all members of the Management Team within the organisation

Policies for review:
GM-002 Organisational Chart Development and Communication
GM-RF-004 Management Team – Terms of Reference
GM-RF 005 Multi-Disciplinary Care Team – Terms of Reference
GM–RF–006 Multi-Disciplinary service Team Terms of Reference

Other policies for review:
GM-012 Quality Assurance and Continuous Improvement
GM-015 Development and Review of Strategic and Operational Plan

Person Responsible
Registered Provider/Person in Charge

Proposed Timescale: 04/11/2016

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Effective management systems were not in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

4. 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:
A full review of the systems currently in place shall be undertaken. A Senior Nurse Project Lead with extensive operational and project work shall be recruited to assist in the review of systems in place.

A. Gaps identified by the inspector shall be reviewed. An internal Gap analysis shall be completed. 7th October 2016

B. All services provided shall be audited. Residents, service users and all stakeholders shall be invited to contribute to these reviews and further improvement and development of the services provided. 31st October 2016

C. Monthly inclusion of systems in place shall be reported directly on to the Management Team, and shall be inclusive of all areas of service, clinical, maintenance, financial and governance. Immediate

Person Responsible
Registered Provider

Proposed Timescale: 31/10/2016

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An annual review had not been completed. An annual review had never been completed in this centre.

5. 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. A full annual Review from September 2015-2016 has been commenced. Commenced
B. All information and data required from all departments for this review is currently being collated by ADON. To be completed by 14th October 2016
C. An Annual Report shall be completed. 28th October 2016
D. A full review of the Annual Report shall guide our planning and development of services for the coming 12 months. 11th November 2016

Person Responsible
ADON/Senior Nurse Project Lead

Proposed Timescale:

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 were not put in place to protect residents' from financial abuse.

The policies in place in relation to managing residents' financial accounts did not reflect practices.

6. 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:
We have fully taken on board what the inspector wished to see in place and will incorporate from the 1st October 2016 a residents cash book for each resident as an addition to the systems in operation and a replacement for one already in place We have also designed an envelope for monthly receipts to be place in and audited by 2 people to replace system in place.

The policy PR-004 Security of Residents' Accounts and Personal Property is in the process of being updated to reflect current practices.

Proposed Timescale: 01/10/2016

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 following risks identified on inspection were not included in the risk register:
- Starling Unit, bay three, room one had a two point extension lead in use at outer side of top of bed. This was a trip hazard.
- Room 15 in Kingfisher had an extension lead in use at outer side of top of bed. This was a trip hazard.
- Five litre and two litre bottles of hair conditioner and shower gel being stored in unlocked bathrooms in Starling and Nightingale Units.

7. 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:
All extension leads in resident's rooms will be decommissioned and replaced with permanent wall sockets by October 21st.

Five litre shampoo containers will be stored in locked cupboards in sluice rooms in accordance with current policy.

2L bottles of shampoo will be decommissioned and replaced with individual containers by 30th October.

Proposed Timescale: 30/10/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Procedures were not consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff. The following poor infection control practices were identified;
- Basins stacked on top of each other in sluice rooms in Starling, Nightingale and Cormorant Unit.
- Basins been stored and stacked on the floor of communal shower rooms and resident ensuites.
- Rust on frame at rear of toilets in communal shower rooms, area could not be cleaned thoroughly due to rust.
- Two litre bottles of shampoo and conditioner in bathrooms used for communal use.
- Shower trolley and shower chair being used in an unclean state in communal shower room.
- Linen trolley, linen skips and incontinence wear being stored in communal shower rooms.
- Clinical waste bin being stored in communal bathroom.

8. Action Required:
Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

Please state the actions you have taken or are planning to take:
Additional stainless steel drainage facilities for hand-basins will be erected in each sluice room and each resident's room.

The rear of all toilets in communal shower rooms will be replaced with stainless steel boxing.

Two litre bottles of shampoo / conditioner are in the process of being decommissioned Additional storage areas are in the process of being commissioned to house linen trolleys / skips.

Spare incontinence wear will no longer be stored in communal bathrooms.

The clinical waste bin has been removed from the bathroom.

All stainless steel work will be completed by 14th October

Additional storage space will be operational by October 30th.

Person Responsible
Registered Provider
Person in Charge

Proposed Timescale: 30/10/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A fire drill had not been practiced by staff in 11 months.

9. 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:
Two Fire Drill have already been undertaken at the Facility on 13th & 14th September. Two additional Fire Drills have been scheduled (to include residents). Third fire drill is scheduled for October 10th A fourth drill is scheduled for October 13th

Proposed Timescale: 13/10/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records were not available to reflect when emergency lighting had been serviced.

10. Action Required:
Under Regulation 28(1)(c)(iii) you are required to: Make adequate arrangements for testing fire equipment.

Please state the actions you have taken or are planning to take:
All documentation regarding the emergency lighting servicing records, while not produced on the date of the inspection, were submitted to HIQA in a reasonable timeframe.

All servicing records required under legislation relating to Fire shall; be maintained centrally and can be found behind the main Reception desk.

Person Responsible
Registered Provider

Proposed Timescale: 27/09/2016

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:
The sitting areas in communal spaces on each of the four units did not appear to be meeting the needs of all residents living there. The following issues were identified on inspection;
- No handrails on any of the corridors in the newly refurbished Starling Unit.
- No handrails beside toilet or beside shower area in a communal bathroom in Nightingale Unit.
- No ventilation system or window in communal bathroom (opposite bedroom 30) in Nightingale Unit.
- No call bell in communal bathroom beside room 22 in Cormorant Unit.
- In the ensuite in room 16 and in the assisted shower (with ceiling hoist) both in Cormorant Unit had no handrails in place.
- Room 43, a newly developed room in Kingfisher Unit had no call bell extension and its ensuite had no ventilation system or window in place and had no hand towel holder or shelve in place.
- Room 44, a newly developed room in Kingfisher Unit had the call bell and over light bed located at the side of the bed and therefore not in direct reach of resident. The call bell in the ensuite located beside the toilet was not long enough to reach the shower area. It had no had no hand rails in place, no hand towel holder, shelve or light over sink in place.
- Rooms 45, 46 and 47 were all newly developed rooms in Kingfisher Unit. The ensuite in each of these rooms had no hand rails in place, no hand towel holder, shelve or light over the sink.
- The ensuite in room 4 in Kingfisher had no handrails in the shower area.
- Twin room 13 in Kingfisher Unit and both twin rooms in Starling Unit did not have screens in place to ensure the privacy of residents occupying these rooms.
- The bedroom walls in room 12 in Kingfisher Unit required repair.
- The ceiling in bed room 13 was badly stained and required repair. The walls in this room were damaged and required repair.
- The ensuite of room 13 had no shelf for storage, toiletries were stored on top of the toilet.
- The walls in bedroom 16 had plaster patched and these areas had not been repainted.
- The windows in a number of single bedrooms in Kingfisher Unit were small and faced onto a grey outside wall. Therefore, these bedrooms were dark as little daylight was filtered into the rooms.
- Equipment such as hoists were stored in the corridors in 2 units.
- The signage on assisted shower room doors read toilet. Signage required review.

- A number of newly constructed en-suite doors had not been painted or varnished prior to installation.

11. 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:
- Handrails are currently being installed across the facility. Handrails will be installed in all communal bathrooms by October 14th and in all individual en suites by November 30th
- Ventilation in the communal bathroom in Nightingale Unit will be installed by 21st October.
- Repairs to walls and ceilings have already commenced. Painting works have already commenced, a full schedule for painting and upkeep of facilities shall in developed. All repairs to walls & ceilings and painting works identified will be completed by October 30th
- A system of auditing room repairs / maintenance has been introduced.
- New signage for bathrooms to be attached to all WC doors. New signage will be in place by November 01st.
- The bedrooms referred to above are in Bay 1 on Starling Unit. Plans are been drawn up to ensure that these rooms have more natural light, larger windows are to be installed. Replacement of Windows to Bay 1 To be completion 31.01.17
- All call bells reflected in the report will be completed and commissioned by 14th October.
- Privacy screens have already be obtained for the two shared rooms.

Person Responsible
Registered Provider

Proposed Timescale: 31/01/2017

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were six staff nurses and one clinical nurse managers post currently vacant in the centre.

The staffing numbers in place were not adequate to ensure the continuity of care of the current 129 residents, the bed numbers were not adequate to ensure the needs of 134 residents' could be met.

Documents outlined in schedule two were not available in one of five staff files

reviewed.

12. 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:
As the application to vary the condition No 7 have been withdrawn.
Current staffing numbers are adequate to ensure continuity of care to the current 130.

All staff files are continue to be audited to ensure the inclusion of all necessary documentation. A dedicated admin staff ensure all HR files are to the required standard and meet regulations. Next scheduled audit report due to Management Team on 24.10.16

Person Responsible
Registered Provider
Person in Charge

Proposed Timescale: 24/10/2016

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All permanent staff did not have performance or personal development meetings completed with their line manager on a regular consistent basis. This is a repeated non-compliance.

13. 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:
Clinical Nurse Managers shall be provided with additional training, mentoring and support to enable them to competently continue to undertake performance appraisal. They shall be supported in the further development of leadership skills.

The Person in Charge shall ensure that the support and training needs for all staff is identified.

The current Organisational structure shall be reviewed. Following the review, educational sessions for all staff shall be implemented to ensure all staff are familiar with and clearly understand their role within the Organisation. All staff shall be clear as to who is their line manager, reporting structure, accountability and responsibility.

Person Responsible Person in Charge
Proposed Timescale: 28/10/2016