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
Lead inspector:	Siobhan Kennedy
Support inspector(s):	Sarah Carter;
Type of inspection	Unannounced
Number of residents on the date of inspection:	132
Number of vacancies on the date of inspection:	3

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National 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 notification of a significant incident or event. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
29 November 2017 11:00	29 November 2017 19:00
30 November 2017 09:00	30 November 2017 17:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Compliant
Outcome 03: Information for residents	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Compliant
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 13: Complaints procedures	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This unannounced inspection was carried out following notifications of significant incidents notified in accordance with the legislation by the management of the centre and unsolicited concerns received by the Authority.

Prior to the inspection, the provider was requested to carry out an investigation of these incidents/unsolicited concerns and provide the Authority with a report of the outcome of the investigation. The provider led investigation report was received by the Authority on 26 October 2017. This inspection primarily focused on the improvement plan outlined in the investigation report to address any matters arising from the investigation and progress in relation to a major and four moderate non-compliances identified in the previous inspection (29 November 2016). These regulations related to safety and safeguarding, governance and management, the well-being of residents, contracts of care and the effectiveness of the complaints process.

The centre is registered to accommodate 135 residents. At the time of the inspection 131 residents were being accommodated, one resident had been admitted to hospital leaving three vacant beds.

During this inspection, inspectors observed practices, communicated with residents, relatives, staff and management and reviewed documentation such as the centre's statement of purpose, care plans, medical records, policies and procedures and records pertaining to accidents, restraint, staffing rosters, training and staff working in the centre.

The provider and the recently appointed person in charge in conjunction with management and staff had worked effectively to address the matters highlighted in the notifications, concerns and matters arising from the previous inspection to bring about improvements for residents.

Residents were positive in their feedback and expressed satisfaction about the facilities and the services and care provided. They confirmed that staff and management worked diligently to meet their needs and preferences.

In the main, relatives were complimentary of the care provided to their relatives and the support received. Two relatives identified some issues but management were aware of these from having carried out a provider led investigation.

Governance and management of the centre was found to be satisfactory. Staff involved in the management of the centre were knowledgeable of the legislation and standards governing the provision of care in the nursing home and were introducing systems and practices to ensure that the centre operated in compliance with the legislation. The person in charge had the necessary criteria outlined in the regulation for the position and staff of various grades were aware of the organisational structure of the centre and the ethos and principles underpinning the provision of nursing and social care in the centre. Some staff members described the changes brought about by the new management structure which in their view led to a positive outcome for residents.

There were measures in place to protect residents from being harmed or suffering abuse. Staff were trained in relation to the detection and prevention of and responses to abuse and the person in charge had investigated incidents/allegations of abuse and taken appropriate action. A record of all incidents occurring in the centre is maintained and notifiable incidents are notified to the Authority within the allocated timescale.

Inspectors saw that there were good opportunities for residents to participate in activities, appropriate to their interests and capacities.

The provisions in place relating to health and safety and risk management were satisfactory.

Residents had good access to nursing, medical and allied health care and the administration of medicines was satisfactory. Residents' assessed needs and

arrangements to meet these assessed needs were set out in individual plans, however, the care planning process required improvement.

Since the last inspection, a number of staff had terminated their contracts and management were actively recruiting on an ongoing basis. The recruitment process was found to be satisfactory. From an examination of the staff rosters, communication with staff on duty and information from residents and the majority of relatives the levels and skill mix of staff were sufficient to meet the needs of residents. There was evidence that staff had access to education and training, appropriate to their role and responsibilities, however, this remains a major challenge during 2018 as twenty-nine new staff members have been recruited.

The action plan at the end of this report highlights the non-compliances which relate to health and social care.

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 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:
The statement of purpose had been reviewed since the last inspection (29 November 2016) and it detailed the aims, objectives and ethos of the centre, outlined the facilities and services provided for residents and contained information in relation to the matters listed in schedule 1 of the Regulations.

The provider was aware of the need to notify the Chief Inspector in writing before changes could be made which would affect the purpose and function of the centre.

Judgment:
Compliant

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
The matters arising from the previous inspection related to filling vacancies in the

management team, developing new systems for monitoring the quality of care and quality of life of residents, developing an action plan in respect of audits and detailing the improvement plan in the annual review. These matters were satisfactorily actioned.

Since the last inspection, the organisational structure has changed. The management team consists of the provider representative, operations manager, director of nursing/person in charge, and two assistant directors of nursing. Clinical nurse managers, a physiotherapist and a senior occupational therapist provides support to staff nurses, team leaders, health care assistants, activity coordinators and their assistants, an assistant occupational therapist and household and catering staff. Management and staff were clear regarding their roles, responsibilities and lines of accountability. The organisational structure was reflected in the statement of purpose.

The senior managers on a rotational basis provide support to the staff team on a weekly basis and a variety of meetings are held in the centre to ensure appropriate clinical governance and management of the centre.

The inspectors were provided with a copy of the annual review for 2016. There was evidence that residents and their relatives had been involved in the review. They had given feedback on seven themed areas linked with the residents' quality of life in the centre. It also contained information regarding the quality and safety of care delivered to residents living in the centre. Data had been gathered about several areas of clinical care, for example, the number of falls, accidents, incidents, and use of restraint.

There was evidence that the new management team were continuously developing systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Judgment:
Compliant

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

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

Findings:
A review of the matter arising from the previous inspection was only examined in this outcome. This related to residents' contracts of care which did not include the fee to be charged to the resident or any additional charges. An examination of a number of contracts showed that this matter had been addressed.

Since the last inspection management have attached an additional sheet to the contract which detailed the charges and this was signed and dated by residents and/or their relatives. This system provided an assurance that residents/relatives were informed of any increase/decrease in their charges.

Each contract of care examined had been signed by the provider and the resident or their next of kin.

Judgment:
Compliant

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:
The centre was being managed by a suitably qualified and experienced nurse (appointed on 1 November 2016) who has authority and is accountable and responsible in conjunction with the provider and the management team for the provision of the service. She works full time in the centre.

She has a degree in nursing, postgraduate diploma in acute medicine nursing and has completed a management course.

During the inspection she demonstrated that she had knowledge of the regulations and standards pertaining to the care and welfare of residents in the centre.
The person in charge and the staff team including the provider facilitated the inspection process by providing documents and had good knowledge of residents' care and conditions. Staff confirmed that good communications exist within the staff team and described some of the new initiatives commenced by the person in charge which has brought about improvements for residents for example the reintroduction of having team leaders.

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

Findings:
The matters arising from the previous inspection were as follows:
– The safeguarding policy had not been implemented as five staff members working during the previous inspection did not have Garda vetting.
– Responsive behaviour care plans did not detail triggers/signs pre empting behaviours and the de-escalation techniques.
– It was not clear which of the two PRN (as required) medicines prescribed for responsive behaviour should be administered first.
– Assessments in respect of restraint did not show alternatives previously trialled.

An examination of documentation pertaining to staff employed in the centre with regard to Garda vetting was examined and found to be in accordance with the legislation.

There are was evidence from the documentation to confirm that management and staff were involved in identifying triggers in respect of residents' behaviours, the frequency of occurrences, the interventions which comforted residents, the types of leisure activities which decreased/increased the responsive behaviours, the effect of noise, pain, mealtimes, rest periods and residents' earlier life histories. During the inspection staff who communicated with the inspectors were able to highlight the typical triggers for residents with responsive behaviours but nursing staff were unable to locate this information within the computerised care planning system. Administration of medicines particularly in relation to PRN (as required) was detailed in a sample of care plans scrutinized.

Management and staff had worked effectively to reduce the use of restraint measures and where restraint was currently being used alternatives which had been trialled were documented. The inspectors noted that restraint levels had been reducing and the management team had detailed this in their quarterly notifications. Physical and environmental restraints were assessed and documented on a multidisciplinary restraint and enabler assessment form. This assessment form detailed the alternatives trailed prior to the use of the restraint and was signed by the nursing staff, General Practitioner (GP) and physiotherapist.
Measures provided to ensure the safety of residents included a policy on safeguarding, an advertised flow chart of the procedures involved in the policy to prompt staff and an assistant director of nursing (ADON) had been given the additional role of safeguarding officer.

Staff who communicated with the inspectors knew how to identify abuse and were aware of their duty to report any concerns. It was evident from the notifications received by the Authority and reviewed prior to and during the inspection that there is a process in place to detect, report and investigate safeguarding issues. Management and staff spoke about their zero tolerance approach to safeguarding issues. Residents who shared their views with the inspectors knew how to report any concerns and they confirmed that they felt safe in the centre and confident that they could raise their concerns.

There was evidence of reported safeguarding incidents being promptly and thoroughly investigated by the person in charge and the safeguarding and complaints officer. The steps taken followed the policy and the timelines in the related procedures.

The provider is an pension agent for 28 residents. A system had been implemented in 2016 to manage residents' monies and an examination of documentation held showed the transactions, up to date balances and signatures. The monies held tallied with the balances. The system was known to residents and staff throughout the centre. There was contingency plans in place to access cash if the accounts staff were not rostered.

Judgment:
Compliant

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 matter arising from the previous inspection related to maintenance of records of fire drills which lacked sufficient detail to improve practice. This was satisfactorily actioned.

Certification and inspection documents were available (daily, weekly, monthly, quarterly and annual checks and tests by staff and external organisations) on fire fighting equipment, emergency lighting tests and fire drills which were conducted as part of staff fire safety training.

All staff working in the centre had received fire safety training in the past 12 months. It was clear from speaking with staff that they knew how to safely evacuate residents' from the centre. A fire warden was appointed on each unit on each shift and the two security men on duty at night time were also appointed fire wardens. Staff knew the fire wardens on duty and knew the procedure to follow in the event of the fire alarm sounding.

All of the doors in the centre are fire doors, and are fitted with electronic or magnetic hold open devices which would close in the event of an emergency situation. However, some doors were blocked by the positioning of furniture but this was addressed during the inspection. Emergency exist and fire assembly points were clearly indicated.

The emergency plan was sufficient to guide staff and management in their roles and duties in the event of an emergency evacuation. There was a clear personal emergency evacuation plan (PEEP) for each resident that clearly identified the resident's cognitive and mobility levels and requirements for assistance in the event of an emergency evacuation either during the day or night time.

Arrangements were in place with a facility in close proximity to the centre in the event of an emergency evacuation whereby residents and staff would be unable to return to the designated centre.

There was an up to date health and safety statement and related policies and procedures.

There were relevant policies in place relating to risk management. A comprehensive risk register which identified the risks and put controls in place either to minimise or fully control the risks was available.

Since the last inspection, the Authority had received a number of notifications in respect of residents requiring medical intervention as a result of an incident/fall. These were examined and it was found that a number of measures had been introduced to reduce the reoccurrence of accidents. This included a multi-factorial approach including assessing, risk rating residents, documenting this information in the residents' care plans, educating staff, reviewing residents' medication, involvement of occupational and physio therapists, and purchasing equipment such as mobility alerts, crash mattresses, and low beds. An analysis of the trends in respect of falls identified that the majority of falls occurred during the handover meeting from one shift to the other and particularly in the evening time so additional staff were rostered to supervise residents.

Documentation examined identified that there had been a reduction in the number of falls during 2017.

Infection control precautions within the centre were satisfactory. The centre was clean and household staff were able to describe the infection-control procedures in place.

Judgment:
Compliant

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

Theme:

Safe care and support

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

Findings:
The matters arising from the previous inspection related to:
• PRN (as required) medication did not include the maximum dose.
• A blue tray to hold pouches required review as it could lead to a medication error.
• Medication errors were not reviewed by the person in charge regarding errors to prevent re-occurrences.

The inspectors reviewed the practices and documentation in place relating to medication management in the centre. There were written policies in place relating to the ordering, prescribing, storing and administration of medicines to residents.

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

Inspectors reviewed the processes in place for administration of medicines, and were satisfied that nurses were knowledgeable regarding residents' individual medication requirements. Nursing staff were observed to safely administer medicines.

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

Medication incidents including medication errors were recorded and nursing staff were knowledgeable of the procedure to be followed. The person in charge monitored medication errors.

Judgment:
Compliant

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

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

No actions were required from the previous inspection.

Findings:
The record of all incidents occurring in the designated centre was maintained and, where required, notified to the Chief Inspector by the person in charge.

The inspectors found that incidents occurring in the centre had been recorded and management systems were in place to carry out an investigation, if necessary, in order to devise and implement an action plan so as to prevent re-occurrences.

Quarterly reports were provided to the Authority in relation to the occurrence of a number of issues identified in the regulations.

Judgment:
Compliant

Outcome 11: Health and Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

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

Findings:
The matters arising from the previous inspection which were not satisfactorily actioned related to the care planning process, the implementation of treatment plans and review of care on a four monthly basis.

The person in charge informed HIQA in the written response to the action plan of the previous inspection report that the care plan would be available to guide care, services and interventions based on residents' assessed functional and cognitive abilities and that these would be reviewed, evaluated and updated no less than every four months or sooner if there was a change in the resident's condition. Senior management agreed to audit the care plans to ensure the system operated effectively. An online data care system was set up and staff were to receive training in this area.

During this inspection there was evidence of duplication in the care plans on the computerized records and the hard copies maintained. Both sets of documents did not tally. Staff spoken to on the day were not aware which care plan was up to date, as

some care plans had been created to meet specific needs but when the need resolved the care plan remained active on the computerized clinical record. A number of care plans were reviewed including one relating to a resident who had fallen, a resident with responsive behavior and a number of care plans for residents with dementia. Residents who communicated with the inspectors did not report being formally consulted regarding their care plans but they did report that they are kept up to date by nursing staff about any changes to their care.

An examination of training records highlighted that some staff members had participated in care planning training during August 2017.

It was noted that there was difficulty in obtaining accurate information regarding the resident's condition on discharge following hospital treatment. Management were liaising with the hospitals to improve communication in this regard.

There were arrangements in place to manage and monitor wounds. The inspectors examined the care plans of two residents with wounds. The nursing team were aware that wound prevention and treatment was multi-factorial and the inspectors saw specific person-centred care plans and regular reviews. Wound assessment charts were in place and provided a clinical picture for comparative purposes to monitor whether the wound was progressing or regressing. There was a policy of photographing wounds and this was practiced by the staff. There was documentary evidence that residents were reviewed by the general practitioner and the tissue viability specialist services. Repositioning charts and monitoring charts for fluid and nutritional intake were available; however the fluid intake chart had not been totalled. Aids such as pressure relieving mattresses were in place for those residents at risk of pressure ulcers. There was a procedure in place to regularly check the correct functioning of these aids and to ensure settings were correctly set.

There was evidence of appropriate medical and allied health care for example, referrals to the dietician, occupational therapists, physiotherapists and speech and language therapists.

There was a comprehensive social and recreational activity timetable in place. Residents reported enjoying the activities on offer. There are two minibuses and there was evidence of regular outings to the community and local pub. The timetable was in keeping with the seasons and there were many plans in place for entertainement and specific events in the lead up to Christmas. There was evidence that residents with specific interests were facilitated and supported to participate. Residents confirmed that they could choose to participate or not in the activity programme provided.

Judgment:
Non Compliant - Moderate

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

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

Findings:
There was a policy in place to process complaints that meets the requirements and regulations.

The complaints process was advertised in an accessible flow chart at reception and at a couple of key locations throughout the building.

A complaints officer had been appointed and the complaints records were reviewed by the person in charge. Complaints were recorded in a systematic way. Inspectors acknowledge that complaints were documented and were available in hard copy in a folder and on the computer system. The level of satisfaction of the complainants was documented on one system. A recent complaint reviewed had been investigated and measures implemented as a result. No evidence was found that the complainant, a resident, was adversely effected having raised the complaint.

Residents and relatives spoken to during the inspection process reported they knew how to raise a complaint. An advocacy service is available in the centre. The inspectors met an advocate who visits the centre for a couple of days a week and residents could identify the advocate as a person they would share their concerns with if they wished.

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):
No actions were required from the previous inspection.

Findings:
From an examination of the staff duty rota, communication with residents and staff the inspectors found that the levels and skill mix of staff at the time of inspection were

sufficient to meet the needs of residents.

Since the last inspection there had been a turnover in staff with twenty-nine new staff members recruited, primarily healthcare staff and one registered nurse.There was a recruitment policy/procedure and a staff member who has worked in the organisation for approximately four years and was appointed to the role of human resources. Inspectors were satisfied with the arrangements for recruiting, supervising and developing new staff which included induction and a probationary period. An annual appraisal system was in place.

There were appropriate numbers of healthcare assistants and nurses on duty during the inspection and staff rosters clearly identified staff by name, role, area of duty and shift times.

Some staff communicated that the only time that there would not be enough staff on duty was in an emergency situation such as a staff member being unwell and not able to commence a shift but management informed the inspectors that there are relief staff available to cover such emergencies.

An assistant director of nursing has taken responsibility for providing a training programme for staff. All staff were up to date on their mandatory training, for example, fire safety, moving and handling, infection prevention and control, and safeguarding. The inspectors were informed that there is a training budget and that non-mandatory training had also been scheduled, for example, thirteen staff members completed training in falls management during November 2017 and dysphagia and food sampling was provided in June 2017.

Staff who communicated with the inspectors demonstrated that they had a good knowledge of the residents in the centre. Residents were full of praise for the staff team and spoke highly of the their competency, friendliness and delivery of care. Inspectors observed staff being patient, friendly and respectful of residents' privacy and dignity.

Systems were in place for vetting, supervising and establishing the level of involvement for volunteers and persons on work experience in the centre.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Siobhan Kennedy
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 report[1]

Centre name:	Hamilton Park Care Facility
Centre ID:	OSV-0000139
Date of inspection:	29/11/2017
Date of response:	22/01/2018

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 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:
Care plans were not formally reviewed within four monthly intervals and revised in consultation with the resident concerned and where appropriate that resident's family.

Some care plans did not reflect the care being provided by staff.

1. Action Required:

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

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

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

• A systematic approach has been put in place to assess the current duplication of care plans.
• The clinical management team will conduct a scheduled in service education in relation to Quality Improvement Plans (QIP) in care planning and documentation. All QIP's initiated and implemented during the last 3rd quarter of 2017 will be discussed thoroughly with the clinical team.
• There is a major QIP adopted by the management to address the issue of regularly updating the individualized care plan within the 4 monthly requirement or sooner if necessary. The approach of implementing the review of the care plans will include the evaluation to monitor the successful implementation of applied interventions.
• The four monthly individualized care plan discussion with residents or their families have been initiated on the 3rd quarter of 2017. Documentation folder in each clinical unit has been in place since the 3rd quarter of 2017 containing the details of discussion with the family members where appropriate.
• An in-service education will be provided to the members of the clinical team in relation to the importance of monitoring the fluid chart of residents. To ensure compliance a specific checklist will be adapted and implemented on a daily basis.

Proposed Timescale: 28/02/2018

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plans or a revised care plan was not made available to the resident concerned and/or relatives with the consent of that resident or where the person in charge considers it appropriate.

2. Action Required:
Under Regulation 05(5) you are required to: Make the care plan, or revised care plan, prepared under Regulation 5 available to the resident concerned and, with the consent of that resident or where the person-in-charge considers it appropriate, to his or her family.

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

• All individualized care plan are regularly updated together with the resident or their families where appropriate. This initiative has been implemented on the 3rd quarter of 2017. There is documentary evidence in place that the discussion has taken place. During family meetings and multi-disciplinary meetings individualized care plans were discussed and made available to the family members. And specific care plans were developed with the family and recorded electronically to address the needs of the

resident.
• All care plans have always been available to the residents and their representative when required and when requested. This will be highlighted again at the residents meeting and the upcoming relatives meeting that the care plans developed to the resident concerned is available or can be made available to ensure transparency of care.

Proposed Timescale: 31/01/2018

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Relevant information about the resident returning from hospital was not obtained.

3. Action Required:
Under Regulation 25(2) you are required to: On the return of a resident from another designated centre, hospital or place, take all reasonable measures to obtain all relevant information about the resident from the other designated centre, hospital or place.

Please state the actions you have taken or are planning to take:
• Regular communication between Hamilton Park and feeder Hospitals has always been in place.
• The specific policy on medical transfer and discharge back to the facility has been reviewed and updated to ensure that all measures to obtain all relevant information about the resident has been sought.

Proposed Timescale: 31/01/2018