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

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Hamilton Park Care Facility
Name of provider:	Hamilton Park Care Centre Limited
Address of centre:	Balrothery, Balbriggan, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	29 May 2024
Centre ID:	OSV-0000139
Fieldwork ID:	MON-0043812

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Hamilton Park is a purpose built care facility located in the countryside a short drive from the town of Ballbriggan. The centre is registered to care for 135 residents, both male and female over the age of 18 years of age. It offers extended care and long term care to adults with varying conditions, abilities and disabilities. Residents with health and social care needs at all dependency levels are considered for admission. It provides general nursing care to residents with dementia, a cognitive impairment, those with a physical, psychological, neurological and sensory impairment. Residents are accommodated on two floors. There are 131 single and two twin bedrooms some with their own en-suite bathroom facility. This modern building has five inner courtyards and an outside garden accessible to residents. There is close access to the restaurants, pubs, and shops.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	112

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 29 May 2024	08:15hrs to 16:45hrs	Frank Barrett	Lead
Wednesday 29 May 2024	08:15hrs to 16:45hrs	Yvonne O'Loughlin	Support

What residents told us and what inspectors observed

Inspectors spoke with eight residents living in the centre, residents who were willing and able to converse. The overall feedback from the residents living in the centre was positive. Residents told the inspectors that they were well looked after and that staff were very kind to them. Many residents told the inspectors that the food was 'good quality' and that they had access to choices at mealtimes, this was evidenced by the menus with clear pictures of what food choices were available.

This was an unannounced inspection carried out over one day. Throughout the inspection, inspectors observed that the staff knew the residents very well and were aware of their individual needs.The dining rooms were bright spacious and clean, residents enjoyed the dining experience as many were laughing and talking with staff. There were enough staff to assist residents during mealtimes and supervise.

The inspectors spoke with visitors on the day of inspection. All expressed their satisfaction with the centre and commented on the excellent service including good food, lovely, warm living arrangements and lovely staff. The inspectors observed that visiting procedures were not aligned to current public health guidance. For example; visitors were required to wear surgical masks in communal areas and had their temperature checked before each visit. Visitors removed their masks when they entered the residents` private rooms. The visitors spoken with on the day had no complaints with the requirement to mask wearing as they said ''the centre had not had an infection outbreak in a long time''.

One resident spoken with said that there was plenty of activities to choose from and that in particular they enjoyed the arts and crafts. An activity co-ordinator was available in each unit to organise and encourage resident participation in events. An activities schedule was on display in the hallway of each unit, and inspectors observed that residents could choose to partake in board games, bingo, quiz games and movies.

Residents had the choice to have their personal clothes laundered in the centre. The feedback from residents on this service was very positive, 'clothes are returned like new' and 'they come back smelling so fresh'. Residents' wardrobes were found to be neat and tidy with ample space for their personal clothing.

There was a dedicated housekeeping room for storage and preparation of cleaning trolleys and equipment. Sluice rooms were located within close proximity to resident bedrooms for the reprocessing of bedpans, urinals and commodes on each unit.The infrastructure of the on-site laundry supported the functional separation of the clean and dirty phases of the laundering process. There was a dedicated clean utility room for the storage and preparation of medications, clean and sterile supplies such as needles, syringes and dressings on each unit.

The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in place and how these arrangements impact on the quality and safety of the service being delivered.

Capacity and capability

This unannounced inspection focused on premises, fire safety and infection prevention and control. Infection prevention and control was reviewed in relation to aspects of Regulation 5: Individualised assessment and care planning, Regulation 9: Residents rights, Regulation 6: Healthcare, Regulation 11: Visits, Regulation 15: Staffing, Regulation 16: Training and staff development, Regulation 17: Premises, Regulation 23: Governance and management, Regulation 25: Temporary absence and discharge, Regulation 27: Infection control and Regulation 31: Notification of incidents.

This inspection also followed up on the fire safety related elements of the compliance plan from the last inspection in July 2023. Inspectors noted that overall the provider had mostly completed the actions committed to in the previous compliance plan. However, this inspection identified a number of fire safety, infection prevention and control (IPC) and premises issues which required improvement and action by the provider.

Management systems in place to mitigate the risk of fire were robust, for example, staff were trained in fire safety, and were regularly completing fire drills, and fire safety audits including escape routes, fire doors, checks of the fire alarm. However, audits of the storage areas in the centre, were not identifying the fire safety risk associated with storage arrangements at the centre. Further concerns were raised relating to the overall risk of fire, fire detection and fire containment at the centre. Fire safety is discussed further under Regulation 23: Governance and management and Regulation 28: Fire precautions.

The premises of Hamilton Park Care facility is extensive, with large external spaces. The centre is laid out over 2 floors, with further staff areas on a second floor. Works had been completed to refurbish a communal day space, and further works were planned to continue the refurbishment programme in other day spaces. This work will improve the environment in the communal spaces for residents using them. The maintenance, and management of the premises required improvement. Storage space within the designated areas of the centre was not sufficient to cater for all the supplies needed within the centre. Extensive storage spaces were present to the rear of the centre, which were not registered as part of the centre. This required review from management at the centre, in order to ensure that appropriate storage facilities are in place. In addition, there was no dedicated private visitors' room, as stipulated in the statement of purpose, as an area previously registered as visitors' space had been converted to an office. Premises issues are discussed further under

Regulation 17: Premises, and the management of premises is also discussed under Regulation 23: Governance and management.

There was good evidence on the day of inspection that residents were receiving good care and attention. For example, call bells were being answered promptly and the inspectors observed kind and courteous interactions between staff and the residents. Inspectors reviewed a sample of staff duty rotas and in conjunction with communication with residents and visitors, found that the number and skill-mix of staff was sufficient to meet the needs of residents, having regard to the size and layout of the centre.

There was an infection prevention and control (IPC) link practitioner who had not yet completed the national IPC link course, this meant that the IPC link was not involved in the network of peer support and learning through the national programme. A review of documentation found that there was access and support from the community IPC team. Infection prevention and control audits were undertaken frequently but did not cover all of the areas of standard precautions, for example linen, sharps and waste management. Audits were not scored and tracked to monitor progress and there was no documented action plans that were time bound.This is discussed under Regulation 23: Governance and management.

An annual review was available and reported the standard of services delivered throughout 2023. The annual review showed that IPC was seen as an important area to continue quality improvements within the centre for 2024.

Inspectors found that the centre had an adequate number of housekeeping staff to fulfill its IPC needs. This observation was supported by reviewing staff rosters and through conversations with the housekeeping staff. There was a housekeeper rostered on each unit on the day of inspection. These staff members were knowledgeable in cleaning practices and processes with regards to good environmental hygiene.

Regulation 15: Staffing

Through a review of staffing rosters and the observations of the inspectors, it was evident that the registered provider had ensured that the number and skill-mix of staff was appropriate for the infection prevention and control and antimicrobial stewardship needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

A review of training records indicated that all staff were up-to-date with infection prevention and control (IPC) training. There was evidence of additional on-site face-to-face training.

Judgment: Compliant

Regulation 23: Governance and management

There were insufficient assurance mechanisms in place to ensure compliance with the *National Standards for infection prevention and control in community services* (2018). Disparities between the finding of local audits and the observations on the day of the inspection indicated that there were insufficient assurance mechanisms in place to monitor quality and safety of the service. For example;

- The infection prevention and control audits were not detailed and took the form of a checklist, with no time bound action plans or quality improvements. This meant that IPC risks may not be identified and dealt with in a timely manner thus increasing the risk of infection spread to residents and staff. For example the IPC audits had failed to identify some of the findings of this inspection; for example the hand hygiene sinks that were not clean, one hand hygiene sink that was out of order and other wear-and-tear issues throughout the centre that did not support effective cleaning.
- On the day of inspection there were no records available to show that antimicrobial medications are appropriately monitored or the effectiveness of the antibiotics used each month. This information is important for the provider to monitor trends and analyse these trends to inform practice and contribute to quality improvements.

In consideration of fire safety and premises matters identified during inspection, improvements were required to ensure that appropriate management systems were in place to ensure the service provided was safe, appropriate, consistent and effectively monitored by the provider. For example;

- The fire safety risk associated with inappropriate storage both internally and within the immediate vicinity in external storage structures which were not part of the registered floor plans of the centre. In many cases, flammable items were stored alongside combustible materials which was contrary to the fire safety policy at the centre.
- Corridor signage which indicated the actions to take in order to safely evacuate the centre were not aligned with the policy at the centre. The policy reflected progressive horizontal evacuation, which was not indicated on the procedures posted on walls throughout the centre. This could result in confusion as staff practice, and training differed substantially from the signage posted on the walls. The signage would direct visitors or residents to

react to a fire in a method which differed from staff understanding and training.
- The assessment of fire safety risk at the centre was limited and did not identify high risk items found on this inspection. While this document provided some useful guidance on measures to take to improve fire safety in the centre, it was not robust enough to reflect many of the issues identified on this inspection as set out in Regulation 28: Fire precautions. This meant that some high risk items were not forming part of the improvement plan at the centre. In view of the findings of this inspection a fullsome assessment of fire safety is required to be completed by the registered provider, informed by their competent fire safety professional and submitted to the office of the Chief Inspector.
- The registered provider had changed the purpose of the previously registered visitors' room to an office, which meant that there was no longer any communal space available for residents where they could receive visitors in private, as required by regulations. This was further compounded by the fact that the Oratory was used as a storage space, contrary to the registration of the centre.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A review of notifications found that the person in charge of the designated centre notified the Chief Inspector of the outbreak of any notifiable or confirmed outbreak of infection as set out in paragraph 7(1)(e) of Schedule 4 of the regulations, within three working days of their occurrence.

Judgment: Compliant

Quality and safety

Overall, the inspectors were assured that residents living in the centre enjoyed a good quality of life. Residents appeared well cared for with their personal care needs being met. Their social care needs were incorporated into their daily care, which they all appeared to really enjoy.

While areas of the centre provided a homely environment for residents and was generally clean, further improvements were required in respect of premises and infection prevention and control, which are interdependent. For example, the

bathroom flooring and the bathroom cabinets were worn in places and as such did not facilitate effective cleaning.This is discussed under Regulation 17: Premises.

The inspector identified some examples of good antimicrobial stewardship. For example, the centre was involved in a quality improvement initiative with Beaumount Hospital to support residents if intravenous antibiotics were required. This meant that in some instances, where appropriate, residents could be cared for in the centre instead of being treated in the acute services. However, the overall antimicrobial stewardship programme needed to be further developed, strengthened and supported in order to progress. For example, nursing staff were not engaging with the "skip the dip" campaign which aimed to prevent the inappropriate use of dipstick urine testing that can lead to unnecessary antibiotic prescribing which does not benefit the resident and may cause harm including antibiotic resistance. Residents were supported to access recommended vaccines, in line with the national immunisation guidelines. The inspector observed kind and courteous interactions between residents and staff on the day of inspection.

The inspectors viewed a sample of residents electronic nursing notes and care plans. There was evidence that residents were comprehensively assessed prior to admission, to ensure the centre could meet residents' needs. Based on a sample of nine care plans viewed, plans were sufficiently detailed to guide staff in the management of urinary catheters and residents with a multi- drug resistant organism (MDRO) and were regularly reviewed and updated following assessments.

Inspectors identified some examples of good practice in the prevention and control of infection. For example, waste, used laundry and linen was segregated in line with local guidelines at point of care. Staff wore clean and tidy uniforms and were bare below the elbow and the correct use of personal protective equipment (PPE) was observed. However, staff did not have access to safety engineered sharps devices which minimises the risk of needle-stick injury. This is further discussed under Regulation 27: Infection control.

The provider had not ensured that hand hygiene facilities appropriate to the setting were provided in line with best practice. For example; hand hygiene sinks were not easily accessible for staff to wash their hands along the corridors if required and staff confirmed that they would wash their hands in the residents' sinks if they needed to do so. This is further discussed under Regulation 27: Infection prevention and control.

Inspectors reviewed arrangements in place at the centre to protect residents from the risk of fire. The centre was equipped with a category L1 fire detection and alarm system. This system ensures that early fire detection would be in place in the event of a fire. However, some rooms within the centre were not fitted with detectors, as required by category L1. Staff were knowledgeable on the procedures to take to evacuate residents in the event of a fire. This was further enhanced by monthly fire drills which recorded various evacuation scenarios, and identified areas of learning for staff, which was further followed up in supplementary training. Improvements were required to reduce the risk of fire including storage arrangements, fire

detection and containment of fires. These are discussed further under Regulation 28: Fire precautions.

Inspectors reviewed the premises of the centre including the external spaces. While the gardens available to residents were large and well-maintained, there was improvement required in the upkeep and maintenance of the centre. Damage to some doors, walls, and equipment was noted during this inspection. Further action was required by the provider to ensure that all areas of the centre, which were registered as communal spaces for the use of residents, were in-fact available to residents. This included an oratory area that was used as a temporary storage space, and was not available for resident use at the time of inspection. These issues are discussed further under Regulation 17: Premises.

There were no visiting restrictions in place and visitors were observed coming and going to the centre on the day of inspection. Visitors confirmed that visits were encouraged and facilitated in the centre. Residents were able to meet their visitors in the communal spaces through out the centre, however private visiting facilities were not available apart from residents' bedrooms.

Regulation 11: Visits

On the day of inspection there was no private room aside from the residents bedroom where residents could meet with a visitor in private.

Judgment: Substantially compliant

Regulation 17: Premises

Overall, improvement was required by the provider to ensure that the premises were appropriate to the number and needs of the residents of the designated centre and in accordance with the statement of purpose prepared under Regulation 3. For example;

- An electrical switch room was accessed from within a bathroom. The room where the electrical cabinet was identified as a separate room on the floor plans.
- An oratory for the use of residents, was not available to residents as it was being used as a temporary storage space for furniture.This was a registered communal space that should be available to residents at all times.

The registered provider, having regard to the needs of the residents of the designated centre, had not ensured that the premises conformed to all the matters as set out in Schedule 6. For example:

- There was damage to some areas of the centre, which was not being actioned including:
  - A sensory room, which was a room off the Nightingale day room, was damaged around the windows, and above the door. The floor was also uneven with loose tiling in a section of the floor. There was an electric heater in this area, however, at the time of the inspection, this room was cold and the heater was not activated.
  - Bathroom facilities were not maintained to an appropriate standard. For example, the baths in two communal bathrooms were not sealed properly, and water was observed pooling underneath.. There was no way of cleaning under the bath, which could result in continuing dampness and possible mould growth under the bath. The bathroom in Nightingale unit was raised and had visible rust on the legs, preventing effective cleaning. Another bathroom in the Kingfisher unit was out of order, and the plumbing was not operational. The provider assured inspectors that a part had been ordered and the bath would be operational once this part was received.
  - Wear-and-tear issues were persisting at the centre. Damage was noted to doors, walls and some areas of the flooring. There was no planned work to address this concern, and this was also a repeat finding from previous inspections. For example, a wall at the hoist storage area in the Cormorant unit was damaged from repeated collisions with hoists.
  - Water damage due to leaks was noted within some storage areas including on radiator covers, and on some ceilings. It was clear that the leaks had been rectified, however, the ceilings and radiator covers had not being repaired. A leak from a skylight in a corridor on the first floor had resulted in damage to the wall below it.
  - Some of the bathrooms had flooring and bathroom cabinets that were in poor repair thus difficult to clean.
  - Ventilation was not working in three bathrooms this meant that there was a damp smell present and increased the risk of mould developing.
- Suitable storage was not available in the designated centre as inspectors observed equipment and supplies used for the centre stored in facilities that were not registered as storage facilities. This required review. In addition, there was inappropriate storage seen on the day of inspection. For example:
  - Storage of sterile products alongside activity equipment. This meant that sterile products may be contaminated and increased the risk of infection spread.

Judgment: Not compliant

Regulation 25: Temporary absence or discharge of residents

A review of documentation found that there was effective communication within and between services when residents were transferred to or from hospital to minimise risk and to share necessary information.

The National Transfer Document and Health Profile for Residential Care Facilities was used when residents were transferred to acute care. This document contained details of health-care associated infections and colonisation to support sharing of and access to information within and between services.

Judgment: Compliant

Regulation 27: Infection control

The provider generally met the requirements of Regulation 27 infection control and the *National Standards for infection prevention and control in community services* (2018), however further action is required to be fully compliant. This was evidenced by;

- Barriers to effective staff hand hygiene were identified during the course of this inspection.This increased the risk of healthcare workers hands being contaminated and increased the risk of infection spread. For example:
    - There were a limited number of dedicated hand wash sinks in the centre and the sinks in the resident's en-suite bathrooms were dual purpose used by residents and staff. This meant that staff hands could be re-contaminated after washing their hands as the sinks were not not designed for clinical hand hygiene.
    - The bottles of alcohol hand gel inside the residents rooms were being topped up from a larger container this increased the risk contamination and could lead to infection spread.
    - One of the hand hygiene sinks in the kitchen was out of order.
    - The hand hygiene sinks in each of the clinical rooms were stained and unclean.
- The needles used for injections and drawing up medication lacked safety devices. This omission increases the risk of needle stick injuries which may leave staff exposed to blood borne viruses.
- Flushing records were not included on the housekeeping checklists. These safety checks are necessary to assist in preventing *Legionella* bacteria developing in the water systems.
- The mop bucket in the kitchen was heavily soiled and in poor repair. Equipment that is dirty and in poor repair increased the risk of surfaces becoming contaminated and can lead to infection spread.

- House keeping facilities did not ensure that best practice standards to reduce infection were maintained. For example, the housekeeping room on Cormorant Unit had no hot water in the hand hygiene sink. The red and blue cloths for cleaning were stored on top of a radiator cover close to staff jackets. This increased the risk of cleaning equipment being contaminated and increased the risk of infection spread.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider did not take adequate precautions against the risk of fire and did not provide suitable fire fighting equipment, for example:

- An electrical switch panel was located within a room, which was inside a ground floor bathroom. The electrical switch room was not sealed from the bathroom, so water vapour and moisture was present in the switch room. Water vapours in this room could increase the likelihood of electrical faults, and therefore increase the risk of fire. There were also two bins stored in this room. The bins were removed immediately by the provider.
- Three full and two empty Oxygen cylinders were stored in a clinical room, however, there was no measures in place to secure the cylinders and prevent collision. Oxygen enrichment as a result of damaged cylinders would increase the risk of fire.
- Electrical sockets were noted as being overloaded, with two separate extension leads, (each with 4 outlets) plugged in to one socket in a nurses station. Electrical overloading is an increased fire risk.
- Storage practice was impacting on the risk of fire within the centre.
    - Storage of flammable items was identified in store rooms, where flammable items such as toiletries, aerosols and hand gels were not stored separate form combustible items such as paper products.
    - A communications and electrical room which was located off the laundry was used as a storage space. Building materials, tools and disused IT equipment were stored in this room. Access to the electrical panels was impeded by the presence of these materials, and this could increase the risk of fire in this high fire risk room.
    - Excessive amounts of combustible building materials and cardboard boxes were stored in a boiler room. This presented a greater risk of fire within this high fire risk room.

The registered provider did not make adequate arrangements for detecting or containing fires. For example:

- While the centre was fitted with a category L1 fire detection and alarm system, a number of rooms did not have fire detection as required by this category of alarm. Examples included but not limited to:

  - Under stairs storage rooms
  - The nurses station in the nightingale unit.
  - Some sluice rooms.
- Containment of fire, smoke and fumes was compromised in some areas of the centre, for example
- A storage area along an evacuation corridor in the Cormorant unit, was fitted with plywood doors. There were no fire detection or containment measures in place at this area. These storage cabinets were in use with a variety of items including some toiletries, linen and PPE. A fire within this space would impact on the evacuation routes for residents staff and visitors in the centre.
- Containment of fire, smoke and fumes was compromised in some areas of the centre, for example:
  - Cross corridor doors, which were on compartment lines, were modified in some areas. The modifications to the size of these doors had exposed the chipboard core, which would result in a much decreased level of containment provided by the doors.
  - Cross corridor doors at the kitchen area were in poor condition. There was large gaping to the perimeters and damage to the edges of the doors and frames in some cases.
  - Bedroom doors had gaps where the doors joined. There were missing smoke seals on these joints also. This required review by the provider
  - Inspectors could not be assured of the fire rating of some ironmongery in use on some doors. This included hinges, handles and locks. Non-fire rated ironmongery would compromise the fire rating of the door, and thus impact the containment.Some doors which were fitted with smoke seals were noted to have these seals damaged. This included the entrance double doors, a nurses office, craft room door. A clinical room did not have any smoke seals fitted.
  - A review of all fire doors was required to ensure that they have appropriate fire containment measures and smoke seals.
  - Inspectors could not be assured that appropriate containment measures were in place within the attic area. This issue was raised when inspectors noted an open attic hatch within a store room. This hatch was adjacent to a compartment wall, and inspectors could not identify the presence of continuing containment measures along the containment line in the attic. The separation of the attic space above the compartment lines would ensure that fire smoke and fumes would not easily spread beyond compartment lines in the event of a fire. Leaving a hatch open posed a risk as it would provide a route for fire smoke and fumes to spread through the centre in the event of a fire. This hatch was replaced immediately.
  - Containment measures were not in place within the under stairs storage spaces. The storage spaces were in use, and fire seals could not be identified around the stairs and in some cases, around the door frames. This could impact on the stairs escape route in the event of a fire in the storage space.
  - Electrical switch panels which were situated in rooms other than electrical risers, were not contained within fire rated cabinets. This would increase the risk of fire spreading from an electrical panel to

other areas within the room, for example an electrical panel in store room 52.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of care plans found that accurate infection prevention and control information was recorded in the resident care plans to effectively guide and direct the care of residents that were colonised with an MDRO and those residents that had a urinary catheter.

Judgment: Compliant

Regulation 6: Health care

Records showed that residents had access to medical treatment and expertise in line with their assessed needs, which included access to a consultant in gerontology, tissue viability and dietitians as required. The IPC link had support from the community IPC team for advice if required.

Judgment: Compliant

Regulation 9: Residents' rights

Residents could not exercise choice to use the Oratory, a place for quiet space and reflection whenever they needed it, as this area was inappropriately used for storage. This impacts on residents' ability to exercise their religious rights.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Hamilton Park Care Facility OSV-0000139

Inspection ID: MON-0043812

Date of inspection: 29/05/2024

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. We have started using the new infection control audit tool which will standardize the methods for monitoring the infection control practices and the environment. In this audit numerical scoring/percentage system is applied and each non-conformance area will be directly addressed.

2. The audit system will also provide feedback results where improvements are needed. The feedback will be directly addressed in the units and overall feedback in our weekly management meetings with the Director of Operations and PIC.

3. Staff education will be covered with our in-house weekly in-service training in the units (which has already started). This consistent specific training on infection control is part of our overall support training matrix and will be led by our designated infection control nurse.

4. The infection control nurse and managers will submit the completed audits which will be reviewed by PIC. Improvement and support plans will be reviewed together with the team. The feedback and support plans will be directly documented in the audit templates.

5. Strengthening surveillance. Specific to monitoring residents' usage of antibiotics in the care facility. Every month, the number of residents (in each unit) prescribed antibiotics specific to respiratory tract infections, UTIs, and others will be documented in a single format. The unit nurse managers and ADONs will populate the data on residents' antibiotic usage monthly. This will be submitted to PIC for review.

5.1 The number and repeat usage will be highlighted. Specific actions will be taken forward to improve the diagnosis of UTI, reducing the reliance on dipstick (send urine

culture if suspected of resistance), and increasing the use of prophylactic treatment Nitrofurantoin.

5.2 Use of clinical scoring systems and guidelines for recommendation in prescribing antibiotics for RTI and other types of infections. This is supported by HSE literature such as:

- UTI in Residential Care Facilities/Nursing Homes,
- Pneumonia (including aspiration pneumonia in nursing homes/long-term care facilities.
- Deprescribing UTI prophylaxis
- Infective exacerbation of COPD.
- Influenza.
- Covid-19
- Cellulitis
- Shingles

5.3 The MDT approach will be applied in reviewing residents' antibiotic usage.
5.4 Antibiotic stewardship data will be centralized in each clinical unit.
5.5 Antibiotic care plans will be developed for each resident using antibiotics.

6. A comprehensive physical review of the whole facility was conducted by the Director of Operations, PIC, and Support Service Manager. The following plans were put in place, such as;

6.1 Re-configuration of storage rooms in each unit specific to equipment storage, and segregation of flammable items away from combustible materials.
6.2 Built up new storage areas with locked doors.
6.3 Re-arrangement of storage areas.
6.4 Any changes will be reflected in the building maps and description in the Statement of Purpose of the care facility.

7. The safety evacuation procedures of the care were reviewed in accordance with the policy of the center. A new safety signage system now reflects progressive horizontal evacuation procedures posted on walls throughout the centre.

8. A comprehensive fire safety risk assessment will be completed by a fire safety professional, this will highlight high-risk areas such as combustible materials and other areas that require immediate attention.

9. The care facility has designated visiting rooms and communal spaces for residents where they could receive visitors in private. This is now fully reflected in the Statement of Purpose of the centre. As for the Oratory, this is now cleared of items and used by the residents.

Person(s) Responsible: DOO, PIC, ADONs, SSM, Unit Nurse Managers and Staff Nurses.
Time Frame: 15/08/2024

Regulation 11: Visits	Substantially Compliant

Outline how you are going to come into compliance with Regulation 11: Visits:
1. The care facility has designated visiting rooms and communal spaces for residents where they could receive visitors in private. This is now fully reflected in the Statement of Purpose of the centre. As for the Oratory, this is now cleared of items and used by the residents.

Person(s) Responsible: DOO, PIC, ADONs, SSM, Unit Nurse Managers and Staff Nurses.
Time Frame: Completed 31/7/2024

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. A separate door was built in the electrical switch room and now can be accessed from outside. And it no longer housed within the bathroom, a wall to separate was construed and a door from the corridor was inserted.

2. As for the Oratory, this is now cleared of items and used by the residents. Sufficient and designated storage areas are in place throughout the care facility.

3. A refurbishment plan was put in place in the resident's sensory room of the Dementia Focus Unit.

4. The maintenance team completed the watertight sealing to prevent moisture in the two communal bathrooms in the Nightingale unit. Visible rust was removed and repainted. The bathroom in the Kingfisher Unit was fixed and is now operational.

5. An overall refurbishment plan was put in place to restore the damage to doors, walls, and other areas of the flooring.

6. The ceilings and radiator covers were repaired, the leak from skylight was sealed and the damage in the wall was repaired and restored.

7. Bathroom flooring and cabinets are included in the overall refurbishment in Cormorant and Kingfisher.

8. The ventilation system in the three bathrooms was repaired and is now operational.

9. A new storage system was designated in the building, this will be reflected in the updated Statement of Purpose of the care facility. Segregation of sterile products, non-

sterile products, and equipment were incorporated.

Person(s) Responsible: DOO, PIC, ADONs, SSM, Unit Nurse Managers and Staff Nurses.
Time Frame: 31/10/2024

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
1. We have placed full compliments of Alcogel bottle dispenser in each resident's room and communal areas. The placement and usage have been risk-assessed, if the resident (s) has been identified as high risk of ingesting it, we will remove it and replace it by issuing toggle alcogel hand sanitizers to staff. As part of the quality service plan in this area, each resident sink will be fitted

2. The Alcogel hand sanitizers in each resident room will be filled with 500 ml pre-filled pump bottles. There is no more requirement to re-fill empty bottles.

3. Upgrading of clinical sinks in the nurse's stations in each unit is in progress. Additional clinical sinks will be added in each unit.

4. Hand hygiene sinks in the kitchen were repaired and are now operational.

5. Upgrading of clinical sinks in the nurse's stations in each unit is in progress. New sets of needle protection devices engineered with sharp injury protections were ordered.

6. Flushing records are now included in the housekeeping checklists.

7. The mop bucket was removed and replaced.

8. The hot water system is always operational, the requirement to run the water in the morning for 15-20 minutes in each unit to let the hot water run through in the pipe system was reiterated to staff and is now part of the checklist early in the morning.

9. An environmental audit will be completed continuously by support services to identify and address issues requiring repair and replacement. System in place for reporting and logging maintenance and repairs.

Person(s) Responsible: DOO, PIC, ADONs, SSM, Unit Nurse Managers and Staff Nurses.
Time Frame: 30/9/2024

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. A separate door was built in the electrical switch room and now can be accessed from outside.
2. All O2 cylinders in the clinical rooms were mounted on the wall.
3. The overload sockets were removed and moved one or more loads from the overloaded circuit to another one. The maintenance team reviewed the electrical capacity and amperage in the panel system.
4. A new storage system was put in place segregating combustible and non-combustible items in the care facility.
5. All items were removed from the communications and electrical room located near the laundry area.
6. All combustible building materials and cardboard boxes were removed from the boiler room.
7. All rooms are now fitted, each with a fire detection system.
8. Doors and presses were removed in the Cormorant Unit. This was certified compliant by the Fire alarm company.
9. The cross corridors were repaired and rectified with fire retardant slips.
10. The cross corridors in the kitchen area were repaired and completed at the end of July 2024.
11. All doors have firelocks and fire retardants. Any damages and seals were repaired. Please see the certificates.
12. All fire doors were reviewed completely at the end of July 2024 to ensure appropriate containment measures.
13. The attic was fully compliant, as per fire regulations. The inspectors were informed on the day of inspection that the partitions were in place and the fire detection system in place in each compartment in the attic space and also was confirmed and certified by the Dublin Fire Brigade on their recent inspection. Please see the attached inspection report done by the Assistant Chief Fire Prevention Officer from Dublin Fire Brigade dated 25/05/2024. Please see the photographs attached of attic partitions.

- Attic conversion photos
- Proof of Conversion/partition/electrical room
- Smoke detector test

Person(s) Responsible: DOO, PIC, ADONs and SSM.
Time Frame: 30/9/2024

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
1. As for the Oratory, this is now cleared of items and used by the residents. At the time of inspection, office equipment arrived due to our refurbishment plans and we have previously advised residents about this. This was fully explained to HIQA inspectors on the day of inspection.

Person(s) Responsible: DOO, PIC, ADONs, SSM, Unit Nurse Managers and Staff Nurses.
Time Frame: Completed 30/05/24

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 11(2)(b)	The person in charge shall ensure that having regard to the number of residents and needs of each resident, suitable communal facilities are available for a resident to receive a visitor, and, in so far as is practicable, a suitable private area, which is not the resident's room, is available to a resident to receive a visitor if required.	Substantially Compliant	Yellow	31/07/2024
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with	Not Compliant	Orange	31/10/2024

	the statement of purpose prepared under Regulation 3.			
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/10/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	15/08/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	30/09/2024
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable	Not Compliant	Orange	30/09/2024

	fire fighting equipment, suitable building services, and suitable bedding and furnishings.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/09/2024
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	30/05/2024
Regulation 9(3)(e)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise their civil, political and religious rights.	Substantially Compliant	Yellow	30/05/2024