Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	St Camillus Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Shelbourne Road, Limerick
Type of inspection:	Announced
Date of inspection:	23 January 2019
Centre ID:	OSV-0000640
Fieldwork ID:	MON-0025960

About the designated centre

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

The designated centre of St Camillus' Community Hospital is located on the main campus of the hospital in Limerick city. The centre is operated by the Health Service Executive (HSE) and is registered to accommodate a maximum of 82 residents. At the time of inspection there were 71 residents registered at the centre. Information provided in the statement of purpose for the centre describes care for people over 18 years of age across the range of abilities from low to maximum needs in relation to advanced age, vascular and neuro-injury, dementia and physical or psychiatric chronic illness. Care planning processes are in accordance with assessments using an appropriate range of validated assessment tools and in consultation with residents. Arrangements are in place to provide residents with access to activities and there is a variety of communal day spaces provided including a large activity area on the first floor. Visiting arrangements are in place and residents are provided with information about health and safety, how to make a complaint and access to advocacy services.

The following information outlines some additional data on this centre.

Current registration end date:	10/06/2018
Number of residents on the date of inspection:	65

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
23 January 2019	10:30hrs to 17:30hrs	Niall Whelton	Lead
23 January 2019	10:30hrs to 17:30hrs	Noel Sheehan	Support

Capacity and capability

This was a short term announced site visit to inform the registration renewal of the centre. The findings of this inspection were that the registered provider, the Health Services Executive (HSE), had failed to ensure that an effective and safe service was provided for residents living in St Camillus Community Hospital. The registered provider had not ensured that the service provided met the needs of the residents living there, particularly in terms of residents' rights, personal accommodation and storage provision. The provider had undertaken to carry out works to the existing building to enhance the lived experience of residents in relation to space, communal areas, dining space and access to same. Although a number of improvements had been completed the provider had not adequately addressed many previously identified regulatory non-compliances, nor had it taken a proactive approach to ensuring that the proposed improvements specified in the response to the compliance plan of the report of the previous inspection in July 2018 had been satisfactorily progressed. On this site visit an evaluation of fire safety was carried out by a specialist inspector in Estates and Fire Safety from the Chief Inspector's office who examined issues of fire safety and was engaged in follow up communication with the provider representative.

The findings from this inspection demonstrated that the Health Service Executive (HSE) is required to address some deficits in overall governance and management as evidenced by:

· a failure to comprehensively review occupancy levels to inform the profile and number of residents who could appropriately be accommodated in the centre

· a failure to address identified fire risks in a timely manner

· findings of repeated regulatory non-compliance from previous inspections

· long-term residents continued to be accommodated in situations which adversely impacted their daily quality of life, privacy and dignity

· following a reduction in the number of residents accommodated in the centre, the registered provider had failed to ensure that the space created by the reduced number of residents was utilised to enhance the quality of life and privacy and dignity of the remaining residents.

Improvements had been made in other areas since the previous inspection, for example occupancy had been reduced from 20 to 17 in Thomond ward, though the impact of this change had yet to be fully realised as the free space that had been created was not being effectively utilised for the benefit of residents for recreation or visits. There was an improved activities schedule in place and 10 residents were seen going off site to the cinema in taxis. Other improvements noted, for example,

were, a programme of staff training on person centred care had commenced, there was a programme of staff rotation between the units, newly recruited health care attendants were being assigned to the activity centre as part of their induction which would support the culture of social care when assigned to individual units. Staffing arrangements continued to improve and additional resources had been allocated to the activities role.

Supervision arrangements included the delegation of responsibilities to nursing staff and the management of multi-task attendants (MTA'S). Staffing arrangements were reviewed with management and confirmed that staffing levels were in keeping with occupancy levels and the layout of the centre. A review of the training matrix confirmed that staff had attended training in mandatory areas such as manual and people handling and safeguarding residents from abuse. The permanent appointment of a director of nursing, the senior nursing position in the designated centre needs to be progressed to effect the changes required to achieve and sustain compliance. All personnel records now have a Garda Síochána vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. Action was incomplete in relation to the segregation of staff roles. This was acknowledged by management.

Measures in place to support effective monitoring of a safe service included regular audits around key areas of care such as falls and medication management. Staff and management responsibilities were identified to ensure action was taken in response to findings identified on these audits. Audit records were maintained and available for reference. Quality management systems included regular meetings to review issues in relation to health and safety or clinical governance. Regional meetings also took place across the organisation to ensure shared learning. However management was not consistently effective in implementing actions to address the issues. For example, as acknowledged in previous inspections, improvements had been made in relation to access to recreational space and resources for activation. However, these improvements had not been extended to all residents and many residents were not facilitated to use recreational space, such as the garden and activity centre, and often had little meaningful choice in relation to how they spent their day.

Inspectors saw various fire safety risk assessments for the designated centre. The latest fire safety risk assessment report dated January 2019 contained a significant number of fire containment issues, most of which related to deficient fire rated door sets. The report had only just been issued on the day previous to the inspection so a definitive time bound plan for implementing a programme of work was not yet available. However, inspectors saw a fire door audit assessment carried out by a fire safety consultant, dated May 2015. This too identified risks associated with doors which required repair or replacement. The provider had carried out extensive works which included replacing fire doors, particularly to resident's bedrooms, but outstanding risks associated with other doors which required replacement or repair remained outstanding.

There was a focussed fire safety risk assessment for Thomand Ward dated September 2018. Inspectors found that red rated risk items, which had a

recommended timeframe of three months, the date for which had passed, had not been satisfactorily addressed. The lack of appropriate fire containment to the long bedroom corridor was still outstanding. It is noted that the provider had arranged for a specialist fire stopping company to complete improvement works, however the bedroom corridor containment works were outstanding.

The provider had made arrangements for fire safety training to be provided to staff, but these arrangements were not adequate to ensure that all staff attended training as required. The person in charge, showed inspectors letters issued to staff indicating that this training was mandatory, but inspectors noted a significant number of staff members were not up-to-date with appropriate fire safety training

In conclusion the findings of this inspection were that the HSE are required to take further action to strengthen the governance and management of this centre for the purpose of improving the quality of life for residents. Areas for improvement that had been identified on previous inspections persisted in relation to personal accommodation, space to meet visitors in private, staffing arrangements and access to meaningful recreation and activities for all residents.

Regulation 14: Persons in charge

The person in charge is new to the role in this centre since the previous inspection and has been assistant director of nursing in St Camillus for some time previously. She is a registered nurse with the required managerial and nursing experience in keeping with statutory requirements. She was actively engaged in the governance, operational management and administration of the service. The person in charge was knowledgeable regarding the regulations, HIQA Standards and her statutory responsibilities. She demonstrated a strong commitment to the development of initiatives and quality management systems to ensure the provision of a safe and effective service.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels were in keeping with the assessed needs of residents having regard to the size and layout of the service. Contingency arrangements were kept under review in relation to managing staff absences. Appropriate systems of supervision were in place with a registered nurse on duty at all times.

Judgment: Compliant

Regulation 16: Training and staff development

Overall, management had implemented measures to ensure that staff received appropriate training and all staff had received training in the provision of person-centred care since the previous inspection. Appropriate arrangements for supervision were in place and a registered nurse was on duty at all times. However, a significant number of staff members were not up to date with fire safety training.

Judgment: Not compliant

Regulation 21: Records

An Garda Síochána (police vetting) disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were available in the designated centre for each member of staff, as required under Schedule 2 of the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider ensured governance arrangements were in place that reflected the size and complexity of the centre and included necessary quality assurance processes. The centre was appropriately resourced to provide an effective service in keeping with the needs of the resident profile.

The Health Service Executive (HSE) is required to address deficits in governance and management as evidenced by:

- a failure to take all necessary action to improve the privacy and dignity of residents
- a comprehensive review of occupancy levels was not carried out to inform the profile and number of residents who could appropriately be accommodated in the centre
- a failure to address identified fire risks in a timely manner
- long-term residents continued to be accommodated in situations which adversely impacted their daily quality of life, privacy and dignity following a reduction in the number of residents accommodated in the centre, the registered provider had failed to ensure that the space created by the reduced number of residents was utilised to enhance the quality of life and privacy and dignity of the remaining residents.
- The arrangements for fire safety training were not adequate to ensure that all

staff attended training as required

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Contracts of care had been revised and had been amended to specify the circumstances of accommodation provided for residents as required by the regulations. Respite and short term residents did not have a contract of care in place as required by the regulations.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

There was a written statement of purpose and function available to all residents and relatives.

Judgment: Compliant

Regulation 31: Notification of incidents

Notifications were completed and returned as appropriate within required time frames in keeping with the regulations.

Judgment: Compliant

Quality and safety

The findings of this inspection are that further improvements are required to enhance the quality of life of residents living in St Camillus' Community Hospital. While there had been some improvements since the previous inspection in relation to the layout of facilities and accommodation, these measures were not adequate to address the shortcomings identified in relation to premises generally. Inspectors were not satisfied that sufficient measures were in place to ensure the safety of residents if a fire was to occur.

The design and layout of the centre overall was institutional in appearance with accommodation for up to 52 residents provided in wards of between three and four occupants. Accommodation in such multi-occupancy rooms detracted from efforts to create a homely and personalised environment. These multi-bedded rooms afforded very limited personal space, privacy or storage for personal belongings. Arrangements, such as privacy screens, while providing a degree of visual protection, could not afford effective personal privacy in relation to noise and odours, for example. Inspectors noted the reduction in bed capacity from 82 to 78 beds, however the registered provider had failed to ensure that the additional space was used to enhance the living space of individual residents. Specifically, space was not re-allocated in multi-occupancy bedrooms to improve the living conditions for residents.

Residents in multi-occupancy rooms were seen to undertake personal activities such as dining and receiving visitors, by their bed. Suitable dining areas were accessible on some units, though the size and layout of the small dining spaces provided on Thomond ward were not suitable and did not support a positive dining experience for residents. While an appropriate dining area was available in the adjacent activity centre on this floor it was not seen to be used for this purpose in the course of the inspection. Personal storage facilities were also limited in the multi-occupancy wards and personal space between beds was often cramped. Lockable storage was available to each resident for the safe storage of valuables. Management and staff acknowledged the impact of premises issues on the quality of life for residents. Similar to previous inspections the privacy and dignity of residents was not assured. Since the previous inspection residents were given access to an individual wardrobe, however the limited size of wardrobes was not sufficient to meet the needs of long term residents.

During the course of this inspection institutional practices were seen to still impact on many aspects of each resident's day to day lived experience. The inspector found that residents were not facilitated to avail of the limited dining space or sitting rooms. While there was an activities programme in place, however, as found on previous inspections the reach of the activities programme was limited. The majority of residents in the multi-occupancy rooms and bays, were seen to have been served lunch by their beds which meant that residents were not able to avail of the social engagement presented by a shared dining experience.

The provider was not taking adequate precautions against the risk of fire in that inspectors noted poor practice in relation to the storage of oxygen cylinders. There were three oxygen cylinders located in one area containing a nurse station, there was another cylinder located in an escape corridor adjacent to a printer and a blood pressure monitor on charge. Inspectors also noted an electrical panel which had been recommended to be enclosed in fire rated construction. This work had commenced but left unfinished as there was not a fire door fitted nor was the plasterboard appropriately sealed. There was an oxygen cylinder located in the same area. When not in use, oxygen cylinders should be appropriately stored in a well ventilated area remote from ignition sources. Inspectors found that the arrangements for the use and storage of oxygen cylinders required review by a competent person, to ensure the safety of residents in the centre. This was brought

to the attention of the provider.

Some fire drills which were conducted by staff only, were found not to simulate the evacuation procedures and consisted more of discussions and staff awareness exercises.

Fire drills carried out as part of fire safety training did not appear to simulate night time scenarios, including night time staffing levels. From a review of drill records, inspectors were not assured that staff would be capable of evacuating each compartment at night time. There were two compartments at ground floor, with eleven and twelve residents respectively. Inspectors saw a record of a drill in the adjoining compartment where it took staff just less than five minutes to evacuate five residents and were not assured there were adequate arrangements in place for staff to evacuate eleven or twelve highly dependent residents from a compartment in the same area.

Furthermore, inspectors were not assured that adequate arrangements were in place to evacuate areas of the first floor where the alternative escape route was down external stairs. There were no records to demonstrate that evacuating ski sheets or ski pads down external stairs had been tried.

Inspectors noted good practices in relation to fire safety. There were ski evacuation sheet audits conducted to ensure all ski sheets were located where they should be and were regularly checked to make sure they were correctly fitted. There were also fire safety audits conducted. Inspectors noted these required improvement due to the findings of this inspection. For example, one entry which was marked ‘yes’, was to ensure that oxygen cylinders are not located in corridors or near any possible ignition sources. This is not consistent to the findings of this inspection.

Escape routes were kept clear and free of obstruction and staff spoken with were mindful of this.

Inspectors found that adequate arrangements for containing fire were not provided. There were a number of doors which either required replacement or repair in order to contain fire. For example, the doors to rooms such as kitchen, store room, clinical room, linen room and so on, opening off a corridor in Sarsfield ward. These were identified in a fire door audit assessment carried out by a fire safety consultancy dated May 2015, detailing doors which require either replacement or repair. It is noted that the doors to resident’s bedrooms were good quality modern doors which had been replaced in recent years and would perform as required in the event of a fire.

In ‘Sarsfield Ward’, there was a hole in the floor separating the ground floor from the first floor, covered up with plywood sheeting. Inspectors were told that this was due to a leak in a bathroom above and was waiting to be repaired. Inspectors were told it was in this state for a couple of months. A breach in the fire rated compartment floor places the residents in the floor above at risk should a fire start in the floor below. This was brought to the attention of the registered provider during the inspection.

Inspectors found that the centre was provided with a fire detection and alarm system, emergency lighting and fire fighting equipment and they were serviced at the appropriate intervals. However, the annual certificate for the emergency lighting system, as set out in the appropriate standard was not available to demonstrate that the system was compliant. Instead a report detailing reason for withholding the aforementioned certificate was available.

In 'Sarsfield Ward', the fire detection and alarm panel was located awkwardly in a corner above a workspace and did not allow easy readability.

Inspectors were not assured that sufficient measures were in place to ensure exits could be readily openable in the event of a fire. Exits, where fitted with key locks did not have appropriate measures to ensure the lock could be opened immediately. While there was a key in a break glass unit adjacent to the door concerned, staff did not carry a copy of the key and each lock required a different key to open it. This was not in line with the guidance in the Department of Environment "Guide to Fire Safety in Nursing Homes" publication.

There were fire procedures in place in the centre and drawings were displayed to show escape routes. The extent, size and location of fire compartments necessary for phased evacuation were not clearly defined on the drawings displayed around the centre

Overall the quality and safety of care required further action to achieve compliance with the regulations for designated centres for Older People. The limitations of the premises continue to impact adversely on the quality of life and safety of residents living there. The provider had previously undertaken to provide a new building for residents by the end of 2019. Inspectors were informed that planning permission was now in place for the proposed extension. The provider had submitted drawings to the office of the chief inspector, however a satisfactory time-bound, costed project plan for this building that demonstrated that the premises would be in compliance by 31 December 2021 had not been provided.

Regulation 11: Visits

There were inadequate facilities in place for residents to meet visitors in private on Thomond ward.

Judgment: Not compliant

Regulation 12: Personal possessions

Appropriate personal storage arrangements and facilities were not in place for all residents, and in particular for many residents in multi-occupancy wards. Facilities in

place were not adequate to meet the needs of residents in long term care.

Judgment: Not compliant

Regulation 17: Premises

Overall, the premises was not fit for purpose for the number of residents living there. The layout, multi-occupancy bedrooms, lack of separate dining and communal living space, limited quite space, all contributed to a premises that could not enable a holistic person-centred approach to living and being cared for with respect and dignity.

The premises did not conform to the matters listed in Schedule 6 of the Health Act 2007(Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and did not fully meet the needs of residents as set out in the statement of purpose.

• Equipment storage facilities on Thomond unit were inadequate.

• Communal dining and seating facilities on Thomond were inadequate.

• Access to outside recreational space was inadequate.

• The space between beds in some multi-occupancy rooms did not provide enough room for a chair or the safe use of assistive equipment, such as a privacy screen.

• Suitable personal storage space was not available for all residents.

Judgment: Not compliant

Regulation 27: Infection control

Management had not fully addressed the areas for improvement previously identified in relation to segregated staff roles. Some members of staff continued in a multi-task role alternating duties in relation to household and cleaning with responsibility for providing personal care to residents in the course of a shift - a work routine which was not in keeping with effective infection control practice. Inappropriate storage and the layout of facilities on Thomond ward also created circumstances of potential risk to residents in relation to healthcare associated infections, these included:

· Equipment and stock was being stored in the assisted bathroom.

· Linen skips were stored in toilet areas.

· Commodes were being stored in a shower area.

· Sluice facilities were co-located in the same area as a toilet facility for residents.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider was not taking adequate precautions against the risk of fire in that the arrangements for the storage of oxygen cylinders required review.

Inspectors were not assured that there were adequate arrangements in place to ensure residents could be safely evacuated.

Adequate means of escape was not provided in that inspectors were not assured that sufficient measures were in place to ensure exits could be readily openable in the event of a fire. Exits, where fitted with key locks did not have appropriate measures to ensure the lock could be opened immediately. While there was a key in a break glass unit adjacent to the door concerned, staff did not carry a copy of the key and each lock required a different key to open it. This was not in line with the guidance in the Department of Environment "Guide to Fire Safety in Nursing Homes" publication.

There was not adequate measures in place to contain fire as detailed in the quality and safety section of this report.

The annual certificate for the emergency lighting system, as set out in the appropriate standard was not available to demonstrate that the system was compliant. Instead a report detailing reason for withholding the aforementioned certificate was available.

The drawings displayed did not show the extent, size or location of compartments to facilitate progressive horizontal evacuation.

Judgment: Not compliant

Regulation 9: Residents' rights

Appropriate arrangements were not in place to ensure that the rights of residents were respected in relation to privacy, dignity and their ability to exercise personal choice. Examples included:

The use of multi-occupancy rooms for up to four residents did not support the receipt of personal care or communication in a manner that protected privacy and dignity. Privacy screens provided a degree of visual protection but did not adequately protect the privacy of the resident in relation to the conduct of personal activities or communication. These screens provided little or no protection from the noise and odours that a resident might experience in multi-occupancy accommodation.

Many residents in multi-occupancy rooms were provided with very limited personal space or storage for personal belongings.
Accommodation layout in these rooms was such that visitors and residents often had to walk through the personal space of other residents for access.

The close proximity of bed spaces limited residents in the extent to which they could exercise choice around activities in their personal space, such as watching TV or listening to the radio, without adversely impacting on other residents.
These circumstances confined residents and limited the extent to which they could be facilitated to exercise choice with regard to how and where they ate their meals, where they spent their day and how or with whom they interacted.

Judgment: Not 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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 11: Visits	Not compliant
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St Camillus Community Hospital OSV-0000640

Inspection ID: MON-0025960

Date of inspection: 23/01/2019

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 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Guidance document on the management of attendance at mandatory training is been developed. Individual copies of the document are to be circulated to all staff members. The document will advise staff that Management of St. Camillus Hospital provide training and it is the individual employee's responsibility to ensure their own training is up to date in line with contracts of employment.
Timeframe: 31st July 2019.

•A planned schedule of Mandatory Training inclusive of Fire Safety training is been circulated to all wards and all staff on e-mail.
•Additional Fire Safety Training was undertaken on 18th and 19th February 2019. Further Fire Training is to be scheduled up to December 2019.
•Person on Fire Training is scheduled for 27th March 2019.
•Fire Safety is part of the induction process for all new staff.
•The Policy Document, Fire Safety Policy and Procedures for St Camillus Hospital set out the responsibilities for all members of staff in relation to Fire Safety.
•The Person Centered Care programme continues, most recent date was 5th March 2019 and a further date scheduled for 9th April 2019.
•Further planned training to year end is as follows: - Preceptorship Training and Assessing in Clinical Practice; Safeguarding Vulnerable Adult; MAPA; Mandatory Hand Hygiene and Basic Infection Control; Risk and Incident Management Training; Quality Care Metrics; IV Medication Administration; Heartsaver course; Inanimate Handling and CPR.
•Timeframe: 31st December 2019.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

New Build:
A Controlled Development Plan for the Centre is at an advanced stage, funding allocated under the Capital Development Programme, which includes a time bound, costed plan for a 75 bedded replacement facility to meet standards as set out under Regulation 17 (2) Schedule 6.

The current status of the project is that planning permission was applied for on 26th November 2018. A request for further information was received on 24th January 2019. There is a considerable amount of additional information being requested, which is currently being compiled by the design team and they anticipate that they will be in a position to submit the information by the end of March. In parallel with this, the Design team are carrying out their detailed design.
Timeframe: 31st December 2021.

In the interim the following measures will be undertaken:
• A review of available space in Thomond unit to facilitate residents' access to social activities and private space will be carried out.
• Remedial work in Thomond unit will take place to enhance the space, which will allow residents to avail of a more enhanced social dining experience.
• Refurbishment of Porch adjacent to Sarsfield unit to afford residents a quiet space and an area to meet visitors in private.
• Renovation of Sarsfield's enclosed garden to facilitate extensive use of outdoor area.
• Timeframe: 31st July 2019.

Fire safety risk assessments/ remedial works:
•The most recent Fire Safety risk assessment was carried out in January 2019 by a fire safety engineer. The Report relating to the 2019 risk assessment was made available to the HSE on the 22nd January 2019 (day before the inspection). This report supersedes the other fire safety risk reports. A tender package is being prepared which will create a schedule of works. The fire safety engineer visited the Centre on the 6th March 2019 to start preparation for the tender package. When this is completed, the HSE will go to tender.
•Tendering will be carried out in line with the HSE procurement process. This assessment had a whole hospital approach, the tender package will be for all of the works and this company will provide sign off on the finished works providing assurance on the fire safety status of the works completed. The red risks identified in the fire safety risk assessment of Thomond Ward will be addressed as part of the tender package. The contractor will be requested to complete this first when the contractor comes on site.

•When the tender package has been awarded through the procurement process, a programme of works and project plan will be developed. The expected timeframe for completion of works is dependent on the outcome of the tendering process and the works to be completed.

•In addition, the previous Fire Safety Consultants came on site in February 2019 to review the 2011 fire risk assessment and the 2015 snag list. When the schedule of works is completed, the previous Fire Safety Consultants will sign off on these elements of work relating to the 2011 and 2015 Reports.

•Fire Training:

Additional Fire Safety Training was undertaken on 18th and 19th February 2019. Further Fire Training is to be scheduled up to December 2019.
Person on Fire Training is scheduled for 27th March 2019.
Fire Safety is part of the induction process for all new staff.
The Policy Document, Fire Safety Policy and Procedures for St Camillus Hospital sets out the responsibilities for all members of staff in relation to Fire Safety.

A schedule of Simulated Fire Evacuations will be conducted, one per month to ensure that all units within the designated centre have a number of Simulated Fire Evacuations undertaken by staff within a twelve month period.
These Simulated Fire Evacuations will be in addition to staff training.
Since inspection, a Simulated Fire Evacuation was undertaken in Shannon Unit on the 10th February 2019 and in Sarsfield Unit on 9th March 2019.
A number of Fire Safety audits are conducted as part of St. Camillus Hospital's robust audit schedule. Ski Evacuation sheet audit is conducted quarterly, Fire Safety audits conducted bi-annually and Fire Safety procedure to be an agenda item at residents meetings.

Timeframe : 31st December 2019

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
Contract for the provision of services:

Contract of care:
A review of the Contract of Care to be undertaken for both Respite and Short term Residents, to ensure that both residents and their families are informed of the services and transparency on charges required to be paid.
Timeframe: 31st July 2019.

Regulation 11: Visits	Not Compliant

Outline how you are going to come into compliance with Regulation 11: Visits:
Visits:

•It is planned to reconfigure a storage room in Thomond Ward to a private sitting room for residents, due to the relocation of an adjacent unit to another area.

Areas identified for private spaces to receive visitors are:
Reconfiguration of dining room in Thomond unit – This can also provide a private room, doors which close to allow for privacy.
Outside of Thomond Ward:
Shannon Ward family room is available.
Refurbishment of Porch adjacent to Sarsfield unit to afford residents a quiet space and an area to meet with visitors in private.
Renovation of Sarsfield's enclosed garden to facilitate use of outdoor area.
Timeframe: 31st July 2019.

Activity Centre is available for use by both residents and visitors from all Units within the Hospital.
Each resident in the designated centre, whom is immobile, has the opportunity with assistance of individual mobility armchairs to be moved to a private sitting room if desired. This will be facilitated by ward staff.
Timeframe: 22nd March 2019.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

Personal possessions:
Individual Unit Level:

Each resident in the designated centre has a private locker with a locked compartment upon request.

Reconfiguration of a multi occupancy bedroom in Thomond unit from a five to a four bedded room has facilitated more personalized space.
Residents and their individual families to be requested to bring in personal items of furniture from home to create a more personalized environment with the added benefit of additional storage space.
Timeframe: 31st August 2019

New Build:
A Controlled Development Plan for the Centre is at an advanced stage, funding allocated under the Capital Development Programme, which includes a time bound, costed plan for a 75 bedded replacement facility to meet standards as set out under Regulation 17 (2) Schedule 6.
The current status of the project is that planning permission was applied for on 26th November 2018. A request for further information was received on 24th January 2019. There is a considerable amount of additional information being requested, which is currently being compiled by the design team and they anticipate that they will be in a position to submit the information by the end of March. In parallel with this, the Design team are carrying out their detailed design.

Timeframe 31st December 2021

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

Premises:

New Build:
A Controlled Development Plan for the Centre is at an advanced stage, funding allocated under the Capital Development Programme, which includes a time bound, costed plan for a 75 bedded replacement facility to meet standards as set out under Regulation 17 (2) Schedule 6.

The current status of the project is that planning permission was applied for on 26th November 2018. A request for further information was received on 24th January 2019. There is a considerable amount of additional information being requested, which is currently being compiled by the design team and they anticipate that they will be in a position to submit the information by the end of March. In parallel with this, the Design team are carrying out their detailed design.
Timeframe: 31st December 2021

Lack of storage facilities:
Residents and their individual families to be requested to bring in personal items of furniture from home, to create a more personalized environment with the added benefit of additional storage space.
A review of the existing storage facilities in Thomond Unit with view to the storage of equipment will be carried out.

Communal Dining Facilities:
All units have availability of dining room space. Residents are encouraged and offered choice to participate in the dining room experience, however a number of residents do request to eat at their bedside.
Remedial work in Thomond unit to enhance the space will allow more residents to avail of a social dining experience.

Space between beds in multi occupancy wards:
Overhead hoists maximize the usage of space between beds in multi occupancy rooms

Private Space:
Areas in Thomond unit have been repainted since inspection, which will allow for inclusion of soft furnishings to facilitate resident's access to private space.
Review of available space in Thomond unit to facilitate resident's access to social activities and private space will be carried out.
Remedial work in Thomond unit to enhance the space will allow more residents to avail of a social dining experience.
Renovation of Sarsfield's enclosed garden will facilitate and encourage use of an outdoor recreational area. Families will be encouraged to use the space for private time with their relative. Staff will facilitate the residents access to outdoor space, weather permitting.
Refurbishment of Porch adjacent to Sarsfield unit to afford residents a quiet space and an area to meet visitors in private.
A number of balcony spaces in both Shannon and Thomond units allow for residents sitting out. Balconies are further enhanced by seasonal planting.

Timeframe: 31st July 2019.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Infection control:

Communication to Union Representatives inviting to talks re division of roles.
Each unit is assigned an Individual Ward Catering Attendant and a specific staff member is assigned the role to cross cover in the absence of the designated Catering Attendant.

Ensure Personal Protective equipment is worn at appropriate times.
Review of available space in Thomond unit with the objective of identifying appropriate storage space for equipment and stock.
Toilet facilities are under review in Thomond unit.
Timeframe: 31st August 2019.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire precautions:

Storage of O2 cylinders:
Following review of oxygen requirements on the units, Oxygen condensers have been purchased which will reduce the necessity for Oxygen Cylinders to be stored on individual units. The exception to above are Emergency trolleys. The three oxygen cylinders referred to in the report have been removed, the electrical panel has been covered and enclosed. In relation to the oxygen cylinder stored on an emergency trolley adjacent to a suction machine and printer as referred to in the report, the area has been decluttered. Photocopier and emergency trolley have been relocated. It has been highlighted to staff the need to be highly aware of the location of Oxygen in relation to heat source .
Fire Safety is an agenda item on the Hospital Management meetings and Clinical Nurse Manager meetings.
Timeframe: 22nd March 2019.

Fire Safety Training:
The Policy document, Fire Safety Policy and Procedures, for the designated centre sets out the responsibilities for all members of staff in relation to fire safety.
The Fire management plan was updated in 2018. All staff have signed the 'Declaration of sight' for the procedures for their work area.
The Centre is a tobacco free campus.
Fire safety is part of the induction process for all new staff.

Since inspection, a simulated fire evacuation was carried out on Shannon Unit on the 10th February 2019 and on Sarsfield Unit on 9th March 2019.
Six monthly simulated evacuations, timed, will be completed by external trainer on site. Next simulated evacuation will be scheduled with the trainer when they are on site on the 27th March 2019.
Person on Fire training is scheduled for 27th March 2019
A planned Schedule of Training is to be circulated to all wards and all staff on e-mail. Fire safety training is mandatory for all staff.

Prior to inspection, personal letters had been issued to individual staff members re attendance at Mandatory Training. A guidance document on the management of attendance at mandatory training will be developed. This will be circulated by individual

copies to all staff members. It will advise staff that Management of St. Camillus Hospital provide training on fire safety and that it is individual employee's responsibility to ensure their own training is up to date in line with contracts of employment.

Repeat Fire Training and planned schedule of Training for remainder of 2019 is being developed.

Monthly Simulated Fire Evacuations will be conducted on individual units to year end, to ensure that all units within the designated centre have at least two night time scenario Simulated Fire Evacuations undertaken by staff within a twelve month period.

These Simulated Fire Evacuations will be in addition to staff training.
Timeframe: Current to 31st December 2019.

Fire safety risk assessments/ remedial works:
Most recent fire safety risk assessment was carried out in January 2019 by a fire safety engineer. The Report relating to the 2019 risk assessment was only made available to the HSE on the 22nd January 2019 (day before the inspection). This report supersedes the other fire safety risk reports. A tender package is being prepared, which will create a schedule of works. The fire safety engineer visited the centre on the 6th March 2019 to start preparation for the tender package. When this is completed, the HSE will go to tender.
Tendering will be carried out in line with the HSE procurement process. This assessment had a whole hospital approach, the tender package will be for all of the works and this company will provide sign off on the finished works providing assurance on the fire safety status of the works completed. The red risks identified in the fire safety risk assessment of Thomond Ward will be addressed as part of the tender package. The contractor will be requested to complete this first when the contractor comes on site. When the tender package has been awarded through the procurement process, a programme of works and project plan will be developed. The expected timeframe for completion of works is dependent on the outcome of the tendering process and the works to be completed.
In addition, the previous Fire Safety Consultants came on site in February 2019 to review the 2011 fire risk assessment and the 2015 snag list. When the schedule of works is completed, the previous fire safety consultantss will sign off on these elements of work relating to the 2011 and 2015 Reports.

Audits:
A comprehensive Fire Safety checklist template has been completed for staff to record checks on a daily/ weekly/monthly basis, held in each unit and in the Fire Register Folder and Fire Register Book for the Centre.
Fire Procedure Documents, inclusive of Fire Safety Policy and handbooks for the wards are in place. The Fire Safety Register is in place on site. The register is updated nightly by the Night Sister. It is also scheduled that the Fire Compliance levels according to the Fire Register book is completed on a daily basis by the CNM on each unit. This includes a visual inspection of every fire panel in the centre, that all fire exits are clear and a weekly checklist of the fire fighting equipment. Copies of test certificates are also kept in this folder.
Visual inspection of is carried out daily/ weekly/ monthly as per the Fire Risk Register/

Additional checklists. Implementation of fire safety audit tool. Weekly fire test carried out by person on reception of fire phone.
Evacuation sheets are audited every three months.
Ski Evacuation sheet audit is conducted quarterly/Fire Safety audit conducted bi-annually and Fire Safety procedure to be an agenda item at residents meetings.

Fire Containment:
Sarsfield Unit: the remainder of fire doors to be replaced will be included in the programme of works as part of the tendering process. The hole in the ceiling arising from a leak has been repaired. The fire detection and alarm panel located in a corner above a workspace is been relocated to another location to maximise accessibility.
Fire alarm and emergency lighting are serviced quarterly and the certificates are issued annually. This is provided by an external, competent person.
The Emergency light certificate was not withheld as stated in the inspection report. The check was carried out in December 2018 and the cert was not available to the HSE until the 4th January 2019. It is readily available for inspection.
The fire suppression system is serviced annually.
Fire equipment i.e. blankets. Extinguishers, hydrants are serviced annually.
Fire fighting water storage tank is available on campus and maintained.
The fire service is familiar with the service/ campus layout and visit regularly.

Keys:
Spare set of keys are held in in each nursing station and fire door keys are tagged and identified.
Fire exits: Mag Locks will be fitted and connected to fire alarm system to release on activation of fire alarm.

Drawings:
Drawings to indicate the extent, size and location of fire compartments necessary for phased evacuation are being revised and redrawn.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

Residents' rights:

New Build:
A controlled development Plan for the Centre is at an advanced stage, funding allocated under the Capital Development Programme, which includes a time bound, costed plan for a 75 bedded replacement facility to meet standards as set out under Regulation 17 (2)

Schedule 6.
The current status of the project is that planning permission was applied for on 26th November 2018. A request for further information was received on 24th January 2019. There is a considerable amount of additional information being requested which is currently being compiled by the design team and they anticipate that they will be in a position to submit the information by the end of March. In parallel with this, the Design team are carrying out their detailed design.
Timeframe 31st December 2021

Interim measures:
Review of available space in Thomond unit and to facilitate resident's access to social activities.
Removal of partition in Thomond unit to enhance the space and allow more residents to avail of a social dining experience.
Refurbishment of Porch adjacent to Sarsfield unit to afford residents a quiet space and an area to meet visitors in private.
Renovation of Sarsfield's enclosed garden to facilitate extensive use of outdoor area.
A number of balcony spaces in both Shannon and Thomond units allow for residents sitting out. Balconies are further enhanced by seasonal planting
Residents and their individual families to be requested to bring in personal items of furniture from home to create a more personalized environment.
Access to activities: Activity centre is open seven days per week with time varying from 08.00hrs to 20:00hrs.
Activities programme now includes a weekly visit to a 'Mens Shed' in an adjoining suburb, which a number of residents attend. This will further strengthen links with local communities.
IT Computer classes currently being undertaken by a number of staff with the aim of facilitating residents' participation on Computers/Surface Pros/IPADS.
of facilitating residents' participation on Computers/Surface Pros/IPADS.

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		31/07/2019
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and	Not Compliant		31/08/2019

	finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	31/12/2019
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 the statement of purpose prepared under Regulation 3.	Not Compliant		31/07/2019
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		31/12/2019
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate,	Substantially Compliant		31/12/2019

	consistent and effectively monitored.			
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.	Substantially Compliant		31/07/2019
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.	Not Compliant		31/08/2019
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building	Not Compliant	Orange	30/08/2019

	services, and suitable bedding and furnishings.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	15/03/2019
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	30/09/2019
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	15/03/2019
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be	Not Compliant	Orange	31/12/2019

	followed should the clothes of a resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	30/09/2019
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	15/03/2019
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	15/03/2019
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated	Substantially Compliant	Yellow	30/04/2019

	centre.			
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.	Not Compliant		30/09/2019
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant		30/09/2019