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:	Atlanta Nursing Home
Name of provider:	Atlanta Nursing Home Limited
Address of centre:	Sidmonton Road, Bray, Wicklow
Type of inspection:	Unannounced
Date of inspection:	22 November 2022
Centre ID:	OSV-0000010
Fieldwork ID:	MON-0038482

About the designated centre

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

The centre is based in a town with access to shops and other amenities such as restaurants and cafes. The centre was originally two private residences and has been converted in to a three- storey centre offering places for up to 43 residents. The centre offers a service to male and female residents over 18 years of age, following an assessment to ensure their needs can be met in the centre. The centre supports residents with low to maximum dependency needs for full time residential care, respite care, convalescence and post-operative care. There are a mixture of single rooms with en-suite, double rooms, and one triple room. There are 10 rooms on the ground floor, eight on the middle and 10 on the top. There are no day services provided in the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	43

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
Tuesday 22 November 2022	10:50hrs to 19:00hrs	Gordon Ellis	Lead
Tuesday 22 November 2022	10:50hrs to 19:00hrs	Frank Barrett	Support

What residents told us and what inspectors observed

This inspection was a one-day inspection that mainly focused on the arrangements that had been put in place by the provider to protect residents from the risk of fire. The inspection was unannounced and was facilitated by the person in charge of the centre. Overall, inspectors noted that the centre was a pleasant building and the residents appeared content in their home. However, a number of significant issues that impacted on the safety of residents in the event of a fire were identified by the inspectors during a walkthrough of the centre and when reviewing relevant documentation.

On the day of inspection, residents were observed going about their daily routine. Residents received visitors in the day room. They appeared comfortable in the centre and were observed chatting with one another. Staff were observed assisting residents with moving through the centre and accessing the garden. Staff interacted with residents in a respectful manner. Inspectors observed the dining experience at lunch time. It was noted that staff offered the residents choices throughout the day in relation to their food preferences and where they wanted to spend their time in the centre.

The centre was located in an urban area within walking distance of numerous facilities including a town centre, public amenities and a beach. The centre consisted of two period houses that had been converted into one building and renovated for use as a designated centre for older persons. This section of the centre extended over three floors. The floors were accessed via a lift and two main staircases. In addition, a single story extension had been added to the rear of the building in recent years. The centre was registered to accommodate 43 residents and the centre was fully occupied on the day of inspection.

The ground floor of the centre contained all of the communal rooms that were used by residents. This included two large sitting rooms, a dining room and a conservatory. The centre's kitchen was located next to the dining room and connected to the dining room via a door. The centre also had a central laundry on the ground floor of the building and a number of staff offices, staff rooms, changing rooms and toilets.

The bedrooms in the centre consisted of 12 single rooms and 14 twin rooms. There was also one bedroom that contained three beds. The ground floor had three double bedrooms, two of which were en-suite. There were also seven single en-suite bedrooms on this floor. The remaining bedrooms were located across the first and second floors. The first floor had a single bedroom and six double bedrooms. Two of the double rooms were en-suite while the other rooms had access to two shared bathrooms with level access showers. The top floor of the centre was located on a split level. On the lower portion of this floor, there were four single rooms, two of which were en-suite and three double rooms, of which two were en-suite. This floor also contained a bedroom with three beds. There were also two shared bathrooms.

Two further double rooms, two shower rooms and two WCs were accessed via a short flight of steps.

Residents' bedrooms were personalised with their belongings, decorations, artwork and photographs. The centre was warm and comfortable. The corridors throughout the centre were nicely decorated with artwork. Overall, the centre was in a good state of structural repair. However, one bedroom had a damp patch on the wall, and a leaking roof. This was discussed with the person in charge and the maintenance supervisor. Assurances were given that work was being done to rectify the failings in the roof of that area of the centre.

Inspectors observed a number of fire safety issues when walking the premises. This included inadequacy of some fire doors, for example in the kitchen. They also noted furniture placed in front of fire exits in the dining area, storage areas on corridors that were not adequately fire-rated and inadequate fire sealing in the boiler room. Inspectors noted issues in relation to the fire compartmentalisation of one area in the building. Fire compartments contain fire and any damage within a particular section of a building. This allows residents to be evacuated to a place of relative safety for a period of time and onwards to an external exit.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced risk inspection carried out to review fire precautions.

Overall, inspectors found that significant action was required in relation to the oversight and management of fire safety arrangements in the centre. While the provider had taken measures to identify areas of service improvement in relation to fire safety, not all issues noted on inspection had been identified by the provider. In addition, the provider did not have a definite timeline for the completion of planned fire safety works. Staffing numbers and staff training were not adequate to ensure the safety of residents in the event of a fire.

The centre was run by Atlanta Nursing Home Ltd, which had two company directors. The inspection was facilitated by the person in charge of the centre. The person in charge was supported by a team of staff nurses, carers, kitchen and household staff.

Improvement was required in relation to the governance and oversight of the fire safety arrangements in the centre. Fire safety checks formed part of the routine auditing procedures in the centre. However, these checks were not always adequate to identify all fire safety issues and did not identify some of the issues that were noted by inspectors. Inappropriate storage practices throughout the centre that

potentially created a fire risk had not been identified by the provider. For example, a storage cupboard had inappropriate levels of paper files that were stacked up to the underside of a fire and smoke detector, potentially interfering with the fire and smoke detector's ability to detect a fire. Inspectors also noted storage of flammable items and exposed electrical wire located underneath a protected enclosed staircase. The provider had not identified these storage issues during the fire safety checks. The provider was issued with an urgent action plan to remove the inappropriately stored items. The provider gave assurances that these items had been removed following the inspection.

The person in charge reported that the provider had employed the services of an external fire consultant to complete a fire safety risk assessment of the centre. However, a copy of the fire safety risk assessment report could not be produced on the day of inspection. The person in charge reported that the risk assessment set out target timelines for the completion of these actions. However, on the day of inspection, a number of the actions had not yet been addressed. The person in charge reported that a programme of works was planned to address the items outlined in the report. This included the upgrade of the emergency lighting system, the fire alarm system and fire doors. There were also plans to address the issues in relation to fire compartmentalisation in the centre. However, the provider was unable to provide definitive dates in relation to the completion of these works.

The staffing arrangements in the centre were reviewed. Inspectors specifically focused on number of staff needed to safely evacuate residents in the event of a fire. Given the mobility needs of the residents and the physical layout of the centre, it was found that there were not enough staff on duty at night to safely complete an evacuation in the event of a fire. This resulted in an urgent action plan being issued to the provider to ensure that an additional member of staff was on duty at night. The provider committed to putting an additional member of staff on night duty to address this need.

Records regarding staff training in fire safety were also reviewed. It was identified that four members of staff required training in fire safety and the person in charge did not have definite dates for when this training would be completed. In addition, in conversation with inspectors, not all staff were knowledgeable of the fire evacuation procedures in the centre.

Overall, the inspectors noted that the governance and management of the premises and oversight of the fire safety arrangements in the centre were not adequate to ensure the safety of residents.

Regulation 23: Governance and management

In consideration of the fire safety matters identified during the inspection, the provider did not ensure that appropriate management systems were in place to

ensure the service provided was safe, appropriate, consistent and effectively monitored by the provider,as evidenced by:

- Risks were not effectively managed in the centre which was evidenced by the number of risks identified on this inspection that had not been addressed by the provider. For example, the provider had not identified the risk of low staffing numbers impacting on the safe evacuation of residents at night-time.
- A failure to ensure the premises was kept in a good state of repair as outlined under regulation 17.
- Evidence of poor oversight and management of fire detection system and emergency lighting as outlined under regulation 28.
- Additional risks associated with evacuation procedures identified during the inspection had not been assessed by the provider and were not being effectively managed.

Inspectors found that there were insufficient resources to ensure the effective delivery of care in accordance with the statement of purpose and function. This was evidenced by;

- Inspectors were not assured that the current night time staffing levels of three staff on duty for 43 residents would be sufficient to safely evacuated, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents. Furthermore, a fire drill was not available on the day of the inspection to demonstrate that residents are afforded safe evacuation from the largest compartment with night time resources. Detail is outlined under the quality and safety section and under regulation 28 Fire precautions.

Judgment: Not compliant

Quality and safety

In reviewing the quality and safety of the measures put in place by the provider to protect residents from the risk of fire, inspectors found that significant improvement was required in a number of areas. This included the maintenance of evacuation routes, the maintenance of building materials and services, and the development of the procedures for the safe evacuation of residents in the event of an emergency.

Inspectors noted that the provider had not ensured adequate means of escape for all residents in the event of a fire. Inspectors found a number of obstructions on evacuation corridors throughout the centre. For example, an ironing board had been fitted to a wall and caused an obstruction in a corridor. In addition, the practice of temporarily storing trollies along corridors caused obstructions and compromised the means of escape from the area in the event of a fire. Inspectors identified a number

of final fire exits that were fitted with a key lock mechanism. One fire exit could not be opened by inspectors until a key was located by a member of staff.

The provider had not ensured that all of the building fabric had been maintained to ensure fire safety. The inspectors were assured as to the likely performance of the doors due to their observations. This included missing fire seals and gaps around fire doors. Fire-rated doors were also missing from cupboards along escape corridors. Inspectors noted areas throughout the centre where the integrity of the fire compartments had been compromised. For example, two compartment doors were not in place on the corridors of the first and second floor. This meant that all bedrooms on that floor were within the same compartment. This impacted on the safe evacuation of residents from one compartment to another in the event of a fire. In addition, inspectors noted that there were inadequate fire seals around pipes and other services that penetrated through compartment walls and ceilings. The provider did not have any definite dates for when these issues would be addressed.

The provider had taken steps to plan for the evacuation of residents in the event of fire. Each resident had a personal evacuation plan that guided staff on the level of support that residents would require in the event of an evacuation. However, a review of the evacuation procedures found that they were inadequate to guide staff in the safe evacuation of residents. For example, evacuation procedures did not account for the deficiencies in the fire compartmentalisation of the building when devising evacuation procedures. In addition, although fire drills had been completed in the centre, these drills were limited and did not simulate the conditions within the centre. For example, staff had practiced single-room evacuations only and had not conducted any drills of a full fire compartment or floor of the centre. This was brought to the attention of the person in charge on the day of the inspection. Subsequently, an urgent action was issued to the provider to; urgently review evacuation procedures, staffing and dependency levels, provide assurances that all staff were aware of the deficiencies in relation to compartmentalisation, and to submit a full compartment evacuation drill for the largest compartment based on night time resources.

On the day of inspection, service records and certificates for the fire detection alarm system and the emergency lighting were not available for review by inspectors. Therefore, inspectors were unable to establish if the building services were being regularly maintained. Further, it was observed that there was a significant lack of emergency lighting in corridors, staircases, and above fire exits. In some cases, emergency lighting was not working. There was also an absence of directional emergency signage throughout the centre.

Due to the totality of deficiencies and fire safety risks identified on this inspection, the provider was required to engage the services of a competent fire consultant to carry out a fire safety risk assessment of the entire centre. Overall, inspectors found that significant improvement was required in relation to the measures that were in place in the centre to protect residents from the risk of fire.

Regulation 17: Premises

While some improvements had been carried out since the previous inspection, parts of the premises still did not conform to the matters set out in Schedule 6 of the regulations, for example;

- Inadequate arrangements of storage facilities were found. The inspectors observed corridors to be cluttered with trolleys and areas of the centre were identified to not be suitable for storage purposes.
- A section of roof was found to be was leaking in a residents bedroom.
- The inspectors were not assured that the capacity of the laundry room was sufficient to afford the separation of dirty and clean laundry.
- Some fire doors were found to be damaged in places.
- Some areas in the centre had holes through ceilings that were required to be sealed up.
- A stud wall along a corridor on the ground floor was found to be unfinished.
- Storage wardrobes in room 9, 14, and 24 (which are twin rooms), were not provided with suitable separation for residents clothing which impacted on the residents privacy and separation of their belongings.
- The floor area of bedrooms 16, 23 and 24 (which are twin rooms), did not meet the requirements of the regulations and did not afford the residents access to a minimum floor space of 7.4m2 to include enough space for their bed, a chair beside their bed and space to store their personal belongings.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider had not taken adequate precautions to ensure that residents were protected from the risk of fire. The service was non-compliant with the regulations in the following areas:

Day-to-day arrangements in place in the centre did not provide adequate precautions against the risk of fire. For example:

- The inspectors observed inappropriate storage practices throughout the centre that potentially created a fire risk. For example, files were stacked up to the underside of a fire detector and items were found underneath a protected staircase. This presented a potential fire risk. The person in charge gave assurances that all items would be removed from these areas to reduce the fire risks. Following the issue of an urgent action, to provider gave assurances that this had been carried out.
- A designated smoking area for residents was absent of a fire apron and suitably sized fire blanket.

- Door bolts were found on some fire exits doors which could cause a delay in the event of a fire emergency. This was raised with the person in charge on the day of the inspection and assurances were provided that these had been removed.
- Quarterly maintenance certification records were not available on the day of the inspection for the emergency lighting system and only one quarterly certificate was available for the fire detection and alarm system for July 2022. The inspectors noted the next service date was October 2022, which indicated the system was overdue for a service from a competent technician to ensure it was fully functional and in working order. In addition, annual maintenance certification records were not available on for the fire detection alarm system.

The Registered Provider failed to provide adequate means of escape as follows:

- An external fire exit route was cluttered and additional emergency lighting was required to illuminate the route of escape in the event of a fire evacuation at night-time.
- There was a lack of emergency exit signage and emergency lighting in some internal corridors, above fire exits and in staircases to indicate the route to access a fire exit.

The Registered Provider failed to make adequate arrangements for detecting, containing and extinguishing fires:

- Inspectors were not assured of the ability of a selection of fire doors to prevent the spread of smoke and fire. A number of fire doors were missing fire door seals and gaps were noted at the bottom and between doors. Two kitchen doors did not meet the required fire rating for a high risk room.
- Arrangements for containment of fire in the event of a fire emergency in the centre required improvement. For example, several areas were noted to have utility pipes or ducting that penetrated through the fire-compartment walls and ceilings (walls and ceilings built in a way to provide a certain amount of fire resistance time), and these required appropriate fire sealing measures)
- Inspectors noted there was an absence of appropriate doors located in the centre to form compartments suitable for the safe evacuation of residents. Ceilings above fire doors that opened into protected staircases on the upper floors did not meet the required fire rating. This compromised containment measures in the centre in the event of a fire emergency.
- The inspectors noted the absence of fire detection in a number of areas for example, in a residents bedroom, in a store room underneath a staircase and in laundry storage cupboards, which are located in a bedroom corridor.
- Internal corridors used as a means of escape in the event fire were compromised. For example, laundry and a fridge were being stored on a corridor.
  The inspectors noted an Automatic Opening Vent (AOV) used to evacuate any smoke that enters a protected stairwell was absent.

The Registered Provider failed to make adequate arrangements for evacuating all persons.

- Arrangements for staff to attend fire training required improvement. From a review of fire training records, the inspectors noted that not all staff had up-to-date fire safety training.
- Evacuation procedures in the centre required significant improvement. The inspectors were not assured that the night time staffing levels of three staff on duty for 43 residents would be sufficient to safely evacuate all persons in the designated centre. Due to the absence of compartmentalisation measures on the upper floors of the centre to perform progressive horizontal evacuation, residents would have to be evacuated into the protected staircases. The inspectors were not assured that residents, some of which would need to be evacuated on ski sheets, would be able to be accommodated in this area in the event of a fire emergency. A fire drill was not available on the day of the inspection to demonstrate that residents were afforded safe evacuation from the largest compartment with night time resources

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 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Not compliant

Compliance Plan for Atlanta Nursing Home OSV-0000010

Inspection ID: MON-0038482

Date of inspection: 22/11/2022

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	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
More robust protocols and reporting procedures in place. Closer monitoring and scrutiny by Senior Management Team (SMT). More scrutiny and verification of works carried out by external consultants.

• Night staff initially increased from 3 staff to 4 staff. Then 4 to 5. Now 4 following additional works and extensive training.
• The Fire detection system has been serviced and a Zone chart completed, Design Cert completed (10/08/2022), Modifications Cert and Annual Servicing Cert completed (10/02/2023).
• Awaiting Date from Contractor to commence upgrade and additions to Emergency Safety Lighting System. – to be completed by 30/06/2023 as agreed with HIQA.
• Weekly fire drills have been taking place since inspection and currently it is scheduled for 15th of every month.
• Ironing board in the corridor removed.
• Kitchen Trollies now stored in Kitchen area.
• Fire seals and gaps. Phase 1 of fire door project awaiting decision from Fire Contractor on Door at Rm 13. Fire curtains to be place by FPS in loft of extension to give compartmentalization as per FPS requirements. Awaiting start date this week.
• 10 Fire doors which required immediate attention have been installed to include the doors at the Kitchen. Remainder of fire doors awaiting start date from contractor.
• Directional emergency signage to be completed by Fire Consultant now that we have Zone Chart.
• Fire Risk assessment – Fire consultant has reviewed our Fire risk assessment and all points are being actioned currently other than liaison with Fire Brigade. Advised to wait until works are completed and then invite Fire Officer to visit.
• All contractors must now supply completion certificates.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Liaise with HIQA on reconfiguration of two rooms. One room has already been designated a single room.
Re-examine Schedule 6 and ensure that all points are addressed. Temporary fix on loose slate and seeking quote and contractor to resolve.

• Storage facilities have been reconfigured.
• Leaking roof in Rm 27 has had a temporary repair. Awaiting quote for scaffolding and repair
• Laundry room system reconfigured.
• Holes in the ceilings to be sealed by FPS.
• Floor area – Bedroom 16, 23 and 24 – please see our correspondence of 31st January 2023. On suite walls being moved back to give the additional floor space required. Work scheduled to commence W/c 6.03.23. Timeline here subject to availability of external contractors but scheduled for 31.03.23.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
On discovering problems with deficiencies with fire alarm, contractors had been appointed to upgrade and rectify system, emergency lighting and fire doors. Contractor engaged to deal with compartmentation issues.
Time frame for completion of fire issues agreed with HIQA as 30/06/23.

• Inappropriate storage underneath the staircase and file room has been removed.
• Smoking Apron, Fire blanket and burns kit in the smoking area has been put in place in January 2023.
• Fire Action instructions have been posted throughout the premises.
• Door bolts in the side entrance have been removed.
• Upgrade and Additional emergency lighting – see above.
• Fire door seals and gaps to be attended to during Phase 2 – to be completed by 30/06/2023.
• Fridge in the extension removed.
• PAT testing commenced with a completion date for all appliances (clinical and non-clinical) by 31/03/23.
• Fire Training for staff – training for all staff is ongoing and the four new staff in question at the time of inspection have received their training in December 2022.
• Fire Risk Assessment completed by external consultant and all areas are being actioned

other than inviting Fire Service to Atlanta. Consultant advised that we wait until all works have been completed to do so.
• Gas slam shut to be linked to alarm panel. Schedule for cleaning of extractors and hoods in kitchen done.
• New alarm service contract in place.

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 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	31/03/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	31/12/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate,	Not Compliant	Orange	06/01/2023

	consistent and effectively monitored.			
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 services, and suitable bedding and furnishings.	Not Compliant	Red	28/11/2022
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/06/2023
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	Red	28/11/2022
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	29/12/2022
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	31/01/2023
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the	Not Compliant	Orange	31/12/2023

	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 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	Red	28/11/2022
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	27/03/2023
Regulation 28(2)(iv)	The registered provider shall	Not Compliant	Red	28/11/2022

	make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.			