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:	St. John's Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Ballytivnan, Sligo
Type of inspection:	Short Notice Announced
Date of inspection:	13 October 2023
Centre ID:	OSV-0000660
Fieldwork ID:	MON-0041704

About the designated centre

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

The aim of St.John's Community Hospital is to provide a residential setting where residents are cared for, supported and valued within a care environment that promotes their health and well-being. The objectives of St. John's Community Hospital include providing a high standard of care in accordance with evidence based practice, providing individualised care to residents and their families respecting the choices, values, dignity and beliefs and ensuring that the residents live in a comfortable, clean and safe environment. St. John's provides a multi-disciplinary approach to the care of residents. The services provided include on-going care of dependant older people, palliative care, dementia care, and physical and mental health care. The centre comprises of five units, Tir na nÓg, Rosses, Cairde, Curam and the Hazelwood unit. St. John's accommodates male and female residents over the age of 18.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	82

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
Friday 13 October 2023	09:30hrs to 18:00hrs	Gordon Ellis	Lead

What residents told us and what inspectors observed

The inspector was met by the person in charge, on behalf of the registered provider, who facilitated the inspection.

Following an introductory meeting, the person in charge accompanied the inspector on a walk around the designated centre.

In the first instance, the inspector walked around the newly refurbished Rosses unit of the building. This unit was tastefully decorated, bright and had a good layout. Accommodation was provided in a series of multi-occupancy rooms which comprised of five three bedded rooms and one four bedded. The largest compartment in this unit contained nine beds. There was sufficient communal space for residents to use and this was provided in sitting room, dining room and family rooms.

Ancillary spaces in the form of a sluice, treatment, store and office rooms were provided. A nurse station was located in this unit with a fire panel. The inspector noted fire evacuation drawings were not present at the panel. The person in charge gave assurances that these were being prepared. The fire panel was healthy and showed no faults on the display.

The inspector noted some issues to a small number of fire doors. The person in charge gave assurances that these would be addressed.

The single storey designated centre comprises of five individual units, three of which were open and accommodated residents at the time of the inspection, while two other units which had undergone refurbishment works were closed to residents. The findings of this inspection relate to all five units.

The inspector also walked around the remaining four unit of the designated centre. Along the corridor that lead to the Tir Na Nog Unit, the inspector observed significant issues with numerous fire doors and inappropriate storage practices. The inspector noted a number of areas where utility services penetrated fire rated walls and ceilings, these required sealing up.

An external storage unit used to house a large quantity of oxygen cylinders to supply piped oxygen into the centre was located at the rear of the centre. However this had not been included in the current floor plans. Furthermore, the inspector saw a number of unsecured oxygen cylinders in this area. These were at risk of being knocked over and was brought to the attention of the person in charge.

External routes were mostly kept clear and provided escape away from the building. Some routes were noted to require additional emergency lighting coverage. This is discussed further in the quality and safety section of this report.

The next two sections of this report presents 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 a short notice announced risk inspection carried out by an inspector of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) with a focus on fire precautions and premises.

The inspection was used to review a newly refurbished unit (Rosses), which was the subject of an application to vary conditions of the registration in regards to; changing the number of beds currently in the centre from 82 to 120 and the de-registering of another separate unit (Curam) from the designated centre. Both of these units were unoccupied on the day of the inspection.

The inspection was also used to follow up on the actions taken by the provider to address the commitments in regard to fire precautions and premises from the last inspection in June 2023. The Inspector found that the provider had addressed the majority of actions required following the last inspection.

There were 82 residents accommodated in the centre on the day of the inspection, and there were no vacancies.

The Health Service Executive (HSE) is the registered provider for this designated centre. There was a clearly defined management structure in place that was accountable for the delivery of safe and effective health and social care support to residents. The designated centre benefits from access to and support from centralised HSE departments, such as the fire and estates.

The designated centre comprises of five individual units, three of which were open and accommodating residents at the time of the inspection, while two other units which had undergone refurbishment works were closed to residents. The findings of this inspection relate to all five units.

On this inspection, the oversight of fire safety management systems and the processes to identify, and manage fire safety risks were not robust to ensure the safety of residents living in the centre. This was evidenced by the significant fire risk identified by the inspector that resulted in an immediate action and significant fire safety risks identified, which are outlined under regulation 28 of this report.

The recently refurbished area of the building had a sufficient number of escape routes and exits. External fire exits were enabled to be easily opened in the event of an emergency. A fully addressable fire alarm detection system was in place and was integrated with the rest of the building. Staff had carried out simulated fire drills to

become familiar with the new layout and fire procedures, in preparation for being registered as part of the designated centre.

Notwithstanding this, the Inspector found some areas needed improvements and maintenance. Gaps were noted underneath a set of compartment doors into the unit. Some of the fire door smoke seals had been painted over which rendered them ineffective to prevent the passage of smoke and a fire door in a treatment room was missing a smoke seal. The inspector observed some fire doors had signs of damage and did not close fully when released. A door closing mechanism was not functioning in a store room and a bedroom when tested.

In addition to this, fire evacuation floor plans were not present at the fire alarm panel and the plans that were on display did not accurately indicate the extent of all compartment boundaries in this unit. The inspector noted that fire doors into residents bedrooms comprised of double doors. One was a regular-sized door and the second was a narrower door. The narrower door was not fitted with a closing mechanism and bed evacuation was the procedure practiced in this unit. Fire doors are required to be fitted with door closers in order to close in the event of a fire to prevent the spread of flame and smoke in the event of a fire. This required a reviewed by a competent person.

In regards to premises, the inspector noted call bell leads were yet to be fitted to resident rooms. The inspector was informed this was scheduled for the following week. In a twin bedroom, only one television was available to both future residents who would occupy this room and was only accessible to one resident.

Significant fire risks and actions that the provider needs to take in relation to fire safety in the centre are set out in the next section of this report and are reflected in the opening section

Regulation 23: Governance and management

The oversight of fire safety in the centre was not robust, it did not adequately support effective fire safety arrangements and keep residents safe.

The provider had not recognised some of the fire risks found on the inspection. The day to day management of fire risk in the centre did not ensure that risks were identified and managed effectively. These findings are set out under Regulation 28.

The providers' in-house checks had not identified significant issues or faults with fire doors, containment deficiencies or means of escape in the centre that had been identified by the inspector on the day. Furthermore, an immediate action in regard to a fire risk had to be issued to the provider on the day of the inspection in relation to inappropriate storage practices as outlined under regulation 28.

Judgment: Not compliant

Quality and safety

In view of the fire safety concerns identified during this inspection, the inspector was not assured that the provider's fire safety arrangements adequately protected residents from the risk of fire in the centre nor did it ensured their safe and effective evacuation in the event of a fire.

It is acknowledged the provider did complete the majority of commitments made after the previous inspection in June 2023. Notwithstanding this, the registered provider was failing to meet the regulatory requirements on fire precautions in the centre and had not ensured that residents were protected from the risk of fire. The provider must make significant improvements in order to comply with the regulations. The inspector found uncertainty over means of escape, fire-containment, visual deficiencies in the building fabric, fire doors, inappropriate storage of flammable and combustible material, and the provision of emergency lighting to external routes which could lead to serious consequences for residents in an emergency. These are outlined in greater detail under regulation 28 of this report.

While there were sufficient fire exits and escape routes provided, the means of escape and emergency lighting to external routes required a review by the provider. A corridor that lead from a church to an external fire exit was observed to be in use as a storage area. Furthermore, the fire exits at either end of this corridor had been locked. There was a lack of external emergency lighting to some escape routes to ensure safe evacuation away from the building during the hours of darkness.

The inspector observed a store room and a room that housed a large mains electrical unit were indicated on the floor plans as two separate rooms. However, both of these rooms were open to each other and were being used to store files, storage cabinets and cardboard boxes for the adjoining accounts office. Furthermore, significant penetrations had breached the fire rated walls that lead into the main corridor. Due to the lack of fire separation between these two rooms, the presence of a large mains electrical units, the inappropriate storage of flammable materials and the levels of services penetrations, an immediate action was issued on the day of the inspection.

The inspector spoke with various staff members on duty in regard to fire safety and evacuation procedures. Staff were confident and very familiar with the practiced evacuation procedures. Staff were up-to-date with fire safety training

The inspector reviewed the fire safety register and noted that parts of it were well organised, in-house periodic fire safety checks were being completed and logged in the register as required. However, deficiencies identified in regard to mean of escape, good house-keeping, inappropriate storage practices of flammable and ignition sources had not been identified in the in-house routine checks.

Service records were available for the various fire safety and building services, and most of these were all up to date. However, the Ansul system located in the kitchen was overdue a service and certificates for the maintenance and servicing of the gas supply system for the centre was not available on the day of the inspection.

There was a fire safety management plan and emergency fire action plan in place. These were found to be comprehensive and informed the fire safety management of the centre. Residents' personal emergency evacuation procedures had improved since the last inspection, were detailed and up-to-date. Simulated fire drills for the largest compartment had been completed based on night time staffing levels and with the addition of two extra residents to help drive improvements. Drill records were detailed and included learning outcomes.

The design and layout of the centre was appropriate for the number and needs of the residents. However, some parts of the centre were in need of repair and action was required to ensure the designated centre conformed to all matters, as set out in Schedule 6 of the regulations. This is discussed further under Regulation 17: Premises.

Regulation 17: Premises

Parts of the premises did not conform to the matters set out in Schedule 6 of the regulations and were in need of repair and maintenance, for example;

- Some areas in the centre were found to have holes and penetrations in walls and ceilings.
- Doors and door frames were found to be damaged.
- Storage practices required a review. For example, a means of escape and an electrical room were being used as storage areas.
- Wiring was exposed and ceiling tiles were stained in a meeting room.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider was failing to meet the regulatory requirements on fire precautions in the centre and had not ensured that residents were protected from the risk of fire. The provider 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:

- An Immediate action in regard to fire risks had to be issued to the provider on the day of the inspection in relation to inappropriate storage practices. For example, a large mains electrical unit was present in a room that was in use as a storage area. The inspector observed a large quantity of flammable items such as files and cardboard boxes were being stored in this area. This was brought to the attention of the person in charge who agreed to arrange for the removal of these items.
- The inspector observed a number of unsecured oxygen cylinders were being stored in an external storage unit that was attached to the designated centre. This unit was used to facilitate the pumped oxygen supply to the centre.

The provider needed to improve the means of escape for residents and emergency lighting in the event of an emergency in the centre. For example, while fire exits had emergency lighting fitted, some external routes were lacking emergency lighting to ensure safe evacuation away from all external fire exits to the designated fire assembly points during the hours of darkness. This required a review by a competent person.

The provider needed to improve the maintenance of the fire equipment, means of escape and the building fabric. For example, the inspector observed the Ansul system (fire extinguisher suppression system) located in the kitchen was overdue a service as the next service was due on the June 2023. Certificates for the maintenance and servicing of the gas supply system for the centre was not available on the day of the inspection. As a result, the inspector was not assured the gas system was being regularly serviced as required.

In a church, the inspector found two fire exits at either end of an escape corridor were found to be locked. This was brought to the attention of the person in charge who sourced a key to unlock the fire exits. In addition, the same escape corridor was observed to be in use a store room. This created a risk that could potentially delay an evacuation from this area in the event of a fire and compromised a protected means of escape.

In addition, the provider needs to review fire precautions throughout the centre. Deficiencies identified in regard to fire doors and means of escape had not been identified on the in-house routine checks of fire doors and means of escape were recorded. Notwithstanding this, the inspector found numerous deficiencies in regard to fire doors and means of escape and fire precautions, which resulted in an immediate action.

Arrangements for containment of fire and detection in the event of a fire emergency in the centre required improvement by the provider. For example, the inspector noted several areas in the centre were noted to have utility pipes or ducting that penetrated through the fire-rated 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. In particular, significant penetrations were found in an electrical room and a store room that contained a large mains electrical unit both of which were located along a protected means of escape.

In addition to this, the inspector was not assured of the ability of a selection of fire doors to prevent the spread of smoke and fire. The inspector noted of the fire doors observed appeared to not meet the criteria for FD 30s performance. Numerous doors had gaps, did not close fully when released and some were missing smoke seals. Furthermore, some office doors had been modified with a letter box, some doors were fitted with non-fire rated ironmongery, were damaged or missing a door closer and some compartment doors had visible gaps over the permissible allowable tolerance.

These deficiencies posed a significant risk to residents in the event of a fire and would allow smoke and fire to spread easily in the event of a fire.

In a kitchen, the inspector was not assured there was adequate gas detection present. In the event of a gas leak, this could potentially not be detected and could create a significant risk.

Arrangements for the display of procedures to be followed in the event of a fire required improvement: Floor pans while display in prominent location required updating as an external oxygen store was not indicated on the floor plans.

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	Substantially compliant
Regulation 28: Fire precautions	Not compliant

Compliance Plan for St. John's Community Hospital OSV-0000660

Inspection ID: MON-0041704

Date of inspection: 13/10/2023

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:
To ensure compliance with Regulation 23(c)
The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.
Compliance will be met by the following:

1. The Registered Provider and the Person in Charge have reviewed the fire safety management systems within the designated center to ensure robust fire safety measures are in place. This was completed on 20/10/23.
2. The Registered Provider and the Person in Charge oversee the centres fire safety management plan. This includes the emergency fire action plan which includes reviews of residents' personal emergency evacuation procedures, simulated fire drills and the learning from these are shared with staff and across Older persons services.
3. The Person in Charge maintains the Hospital Fire Register and liaises with HSE Regional Fire Prevention Officer on all aspects of fire safety management.
4. All fire fighting equipment is maintained by a competant external fire company. This ensures fire fighting equipment is present and in full working order.
5. The Person In Charge ensures all staff have attended mandatory fire training and this is provided on an annual basis.
6. Daily checks of all fire exits and escape routes are performed and this is recorded on the thrice daily quality risk and patient safety report. This is reviewed by the Person In Charge or their designate on a daily basis.
7. Immediate action was taken by the Registered Provider and Person in Charge on the day of the inspection 13/10/2023 to commence removal of inappropriately stored items as identified by the inspector.
8. All items inappropriately stored in the second patient accounts office have been removed since the 16/10/2023.
9. The Registered Provider and Person in Charge conducted a robust fire safety review of the designated center with the HSE Regional Fire Prevention Officer on the 31/10/2023

to review means of escape, fire-containment, visual deficiencies in the building fabric, fire doors, inappropriate storage of flammable and combustible material, and the provision of emergency lighting to external routes.
10. Following this fire safety review an immediate action plan to address deficiencies was implemented as and from 31/10/23.
11. All fire doors were reviewed and remedial works identified. All remedial works to fire doors were completed on the 10/11/2023.
12. The two damaged fire doors identified to be replaced on the Cairde unit are ordered and will be fitted by the 15/03/2024.
13. The second patient accounts office is not in use since the 16/10/2023.
14. A programme of electrical works is scheduled to be completed by the 28/02/2024 by an external contractor on the second patient accounts office.
15. The Church of Ireland final exit door from the sacristy located off the main church room has been decommissioned from the 09/01/24. The final exit signage has been removed by an external fire company and is no longer a designated exit door as of the 09/01/2024.
16. The Registered Provider and the Person in Charge conducted a robust fire safety review of the designated center with the HSE Regional Fire Prevention Officer on the 31/10/2023. All bedroom fire doors were reviewed as part of this safety review.
17. The fire doors to the residential bedrooms comprise of one regular and one narrow door. The regular doors only provide the required adequate clear width for the residents and staff to use on a daily basis using frames / wheelchairs. The narrower door is only opened for bed transfers which does not happen every day. The narrower door otherwise remains in a closed locked position at all times. The signage on the narrow door refers to fire door "keep closed" for this reason. There are daily checks in all units of the narrower door to ensure it is in a locked position commenced the 15/01/2024. The regular door is fitted with a free-swing self-closer connected to the fire alarm.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
To ensure compliance with Regulation 17(2)
The registered provider shall, having regard to the needs of the residents of a particular designated center, provide premises which conform to the matters set out in Schedule 6.
Compliance will be met by the following:

1. The Registered Provider and the Person in Charge reviewed all storage practices within the designated center, to ensure all items were appropriately stored. This was completed on 16/10/2023.
2. The Person in Charge is overseeing the repair work to any holes or penetrations within the ceiling and wall spaces by an external contractor. This will be completed by the 02/02/2024.
3. The two damaged fire doors identified to be replaced on the Cairde unit are ordered and will be fitted by the 15/03/2024.

4. The Church of Ireland final exit door from the sacristy located off the main church room has been decommissioned on 09/01/2024. The final exit signage has been removed by an external fire company and is no longer a designated exit door as of the 09/01/2024.
5. The Person in Charge is overseeing the replacement of ceiling tiles and the fire proofing of exposed wires in the training room by an external contractor. This is to be completed by the 02/02/2024.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
To ensure compliance with Regulation 28(1)(a)
The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable firefighting equipment, suitable building services, and suitable bedding and furnishings.
To ensure compliance with Regulation 28(1)(b)
The registered provider shall provide adequate means of escape, including emergency lighting.
To ensure compliance with 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.
To ensure compliance with Regulation 28(1)(c)(ii)
The registered provider shall make adequate arrangements for reviewing fire precautions.
To ensure compliance with Regulation 28(2)(i)
The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.
To ensure compliance with 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 center.
Compliance will be met by the following:

1. The Registered Provider and the Person in Charge conducted a full fire safety review of the designated center with HSE Regional Fire Prevention Officer on the 31/10/2023 to review means of escape, fire-containment, visual deficiencies in the building fabric, fire doors, inappropriate storage of flammable and combustible material, and the provision of emergency lighting to external routes. All fire doors were reviewed and remedial works identified. All remedial works to fire doors were completed on the 10/11/2023.
2. The two damaged fire doors identified to be replaced on the Cairde unit are ordered and will be fitted by the 15/03/2024.
3. The Person in Charge reviewed the storage in patient accounts, all items inappropriately stored in the second patient accounts office have been removed since the 16/10/2023.
4. The second patient accounts office has not been in use since the 16/10/2023.

5. A programme of electrical works is scheduled to be completed in the second patient accounts office. This will be completed by the 28/02/2024 by an external contractor.
6. The Church of Ireland final exit door from the sacristy located off the main church room has been decommissioned on 09/01/2024. The final exit signage has been removed by an external fire company and is no longer a designated exit door as of the 09/01/2024.
7. The Registered Provider and the Person in Charge conducted a review of the designated center with the HSE HSE Regional Fire Prevention Officer on the 31/10/2023 to review means of escape, fire-containment, visual deficiencies in the building fabric, fire doors, inappropriate storage of flammable and combustible material, and the provision of emergency lighting to external routes. All bedroom fire doors were reviewed. The fire doors to the residential bedrooms comprise of one regular and one narrow door. The regular doors only provide the required adequate clear width for the residents and staff to use on a daily basis using frames / wheelchairs. The narrower door is only opened for bed transfers which does not happen every day. The narrower door otherwise remains in a closed locked position at all times. The signage on the narrow door refers to fire door "keep closed" for this reason. There are daily checks in all units of the narrower door to ensure it is in a locked position commenced the 15/01/2024. The regular door is fitted with a free-swing self-closer connected to the fire alarm.
8. The Registered Provider commissioned a review of all fire exits, signage and lighting. This was completed on the 31/10/2023 by the HSE Regional Fire Prevention Officer and a competent external fire company. As part of the Fire safety review on the 31/10/23 all final exits were fitted with emergency lighting and in working order.
9. Additional bulkheads and direction exit signage are in the process of being installed to ensure all internal and external routes are provided with emergency lighting that ensure safe evacuation away from all external fire exits to the designated fire assembly points during the hours of darkness. The additional works are due to be completed by the 26/01/2024.
10. The safe storage of Oxygen cylinders has been reviewed by the Person in Charge on 08/01/2024.Oxygen cylinders within the external oxygen manifold have all been secured appropriately. This was completed on the 08/01/2024.
11. The Ansul system located in the kitchen was serviced on the 20/11/2023 and certificates of compliance are available for inspection. The Person in Charge now has a process in place to ensure this is serviced and maintained on an annual basis.
12. The maintenance and service record for the gas supply system are available for inspection. The Person in Charge now has a process in place to ensure this is serviced and maintained on an annual basis.

13. The Registered Provider and Person in Charge are overseeing the repair and remedial works identified during the inspection to include any holes or penetration with the ceiling and wall spaces by an external contractor. These works will be completed by 02/02/2024.
14. The Registered Provider has completed a review of Co2 detectors in the kitchen. Following this review, 2 X Co2 detectors were installed in the Kitchen by a competent fire safety company. This was completed on 22/12/2023.
15. The Person in Charge has requested updated floor plans from HSE Estates department to include the external oxygen store. This will be provided by the 31/01/2024.

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.	Substantially Compliant	Yellow	15/03/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	15/03/2024
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment,	Not Compliant	Orange	28/02/2024

	suitable building services, and suitable bedding and furnishings.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	26/01/2024
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	09/01/2024
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	31/10/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	15/03/2024
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 centre.	Substantially Compliant	Yellow	31/01/2024